AN ARGUMENT CONCERNING THE MEANING AND RELEVANCE OF PHILOSOPHICAL ENQUIRIES IN NURSING

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I declare that this thesis
has been written by me,
and that the work is entirely
my own

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ABSTRACT

In the search for nursing knowledge for practical, professional, academic and personal purposes, criteria for its identification need to be developed. The conceptualization of a nursing perspective emerges as a primary and fundamental task in this endeavour.

Current attempts to develop nursing knowledge are often irrelevant, arbitrary, and inappropriate. The conviction that empirical methods of investigation alone cannot produce nursing knowledge has led to infrequent, generally fragmented and often confused attempts to clarify the meaning of philosophical enquiries in nursing.

Most claims to a 'philosophy of nursing' misrepresent ideological statements as philosophical concerns and obscure the essential meaning of philosophical enquiries. 'Nursing ethics' fail to engage in the criticism and analysis of moral arguments. Theory construction and development indicate essential philosophical concerns in nursing.

It seems necessary to examine philosophers' explanations of the purposes of philosophy, the nature of philosophical problems, the methods used in philosophical enquiries, the contents of the discipline of philosophy, and its relationship with other disciplines.

The potential development of nursing knowledge by relevant philosophical enquiries demands that four fundamental philosophical tasks be accomplished, namely, limiting the search for knowledge, thinking methodically and systematically about nursing, identifying the philosophical demands of the research process, and constructing and developing nursing theories.

The essential nature of philosophical enquiries demands that all nurses need to participate at some level and to some extent in accomplishing these four fundamental tasks, if nursing is to be established as a practice discipline.

FOREWARNINGS

In presenting my argument, I have adopted certain features which ought to be explained at the beginning for the reader's ease and comfort.

One of my principal aims in writing this thesis is to demonstrate a particular kind of argument. It lies in the nature of a philosophical enquiry, especially when it is conducted by means of an internal dialogue, that the argument reaches points where a question needs to be pursued that may appear to be somewhat digressive. I could, of course, have tidied away any such *digressions* (and if they were of a minor nature, I have done so). But it appears to me to be an essential characteristic of this kind of investigation, that questions emerge which must be dealt with in the enquirer's mind before the main thread of the argument can be developed further.

I have therefore deliberately exposed what might be called the *occasionally* cluttered underground route of my thinking rather than provide the reader with a guided tour through an uncluttered overground route from which all obstacles and thickets of potential confusion have been removed. Part of my concern of showing the development of my thoughts and of the resulting argument is the decision not to separate or split up trains of thought by introducing *subheadings*.

Although the reader's task might have been made easier in some ways by indicating with a subheading that a particular point has been dealt with and another one is now being considered, I fear that this advantage may be outweighed by greater disadvantages.

First of all I need to express a fundamental objection to the impression that may be created by subheadings (rightly in other enquiries, but wrongly here).

This is that they tend to convey the idea that all that needs to be said about a topic, for example, about the purposes of philosophical enquiries, is to be found under that subheading. This is, and cannot be the case in my argument. More may be said about a particular point in one place but a great deal must be said about it elsewhere. What I wish to avoid is the impression of finality that organising material under subheadings might create.

Secondly, using subheadings might lead to the expectation that reading what follows a particular subheading should be perfectly intelligible as it stands.

Although I have striven for intelligibility at all times, the nature of this argument demands that one hears all of it before one may accept or dismiss it wholly or in parts.

I would like to think that this thesis is read as a whole. But having indicated distinct parts, I would expect each part to be capable of a comparatively independent scrutiny.

I have adopted a particular way of indicating words and phrases which may not have an indisputable meaning, or which, in my opinion, are used frequently in a somewhat narrowed, misleading or distorted form, by putting *'single quotation marks'* around them.

For example, 'science' means that I am not certain whether in the given context the word as it is usually employed, is appropriate and unambiguous.

I quite like the idea of calling the words and phrases which I have indicated in this way, 'fuzzies'.

Anything in *"double quotation marks"* indicates a "quote", be it a word, a sentence, or a paragraph, and its acknowledgement should be found close by.

Occasionally, arabic figures in the text refer to *notes* at the end of each part of the thesis.

I adopted this convention to provide myself with an opportunity to elaborate, question, or explain a point when such elaboration, questioning, or explanation would have seriously interrupted the flow of that part of the argument. Another important need that is partly fulfilled by the notes was to find ways of indicating the essential dialectic of my argument.

The essence of this kind of enquiry is the participation of others who question, suggest answers, accept counter-questions and examine proffered answers; or to use another phrase, who take issue with me.

I have tried to take issue in this sense in three main ways: by questioning and examining what other people have said (in writing), by questioning myself, and by responding to issues raised by those who came along on this journey of discovery.

The first two ways of taking issue are whereever possible, made explicit in the main text of the argument. The third way may, on occasion, be found in the notes.

Finally, I have found it useful in thinking about some of the issues which I am about to present, to use German words in order to clarify quite essential distinctions. I trust that their meaning becomes quite apparent in the context of the discussion where I found them to be rather indispensable. As I do use them repeatedly, however, without each time explaining as much about them as when they were first introduced, I offer a brief *glossary* as a guide, should one be needed.

GLOSSARY OF GERMAN WORDS USED IN THE ARGUMENT

Aufhebung	cancellation or nullification by two opposing forces
Bedeutung	meaning in a particular context; also the importance a person attaches to words, objects or actions
bedeutungslos	without meaning in a particular context; without importance for a situation or a person
Bild	literally, a picture; also a mental picture or image; an impression
Bildung	the process by which a person acquires, forms and develops knowledge; a sound comprehensive knowledge of the world past and present; the development of a conscious, articulate world view
Gestalt	form; configuration; a pattern with its distinct features; an impression of the totality of the features of an object, a situation, a process
Können	the ability to do something; to be able to do something well in a particular sphere
Kunst	the ability to do something creatively and elegantly, par excellence, in a pleasing manner; complete mastery in a particular sphere; the art of the outstanding practitioner
Praxis	the field of practice
Richtigkeit	the rightness of a claim; without mistakes; accuracy
Sinn	rational meaning of words and actions; purpose and general validity

sinnlos	without rational meaning; for no purpose; invalid
Wahrheit	the truth of a claim; congruence with the facts; agreement between thoughts, words and actions
Weltanschauung	a particular way of looking at the world and the nature of man; an acceptance of particular purposes and goals in the development of the world and man; a world outlook; an ideology
Weltbild	a person's comprehensive knowledge of the world and man; a picture, mental image, or impression of the world around us and of our place in it
Wissen	clear, precise and rational knowledge
Wissenschaft	systematic, methodical search for knowledge and understanding in a particular field with appropriate methods of enquiry, and with known criteria for the acceptability of results; a discipline characterized by research, and the ordering of knowledge

The explanations in this glossary are based on

Duden : Bedeutungswörterbuch
Der GroBe Duden Band 10
Bibliographisches Institut Mannheim/Zürich
Dudenverlag 1970

INTRODUCTION

Words often fail us when they are most needed. There are no words in the English language to indicate briefly but adequately what has led me to the writing of this work. The lack of linguistic and conceptual equivalents to some German words like '*Bildung*' and '*Wissenschaft*' will not only make these introductory comments lengthier than they might have been, but it may also reveal important epistemological questions in nursing.

This thesis is essentially concerned with a particular aspect of nurses' current quest for knowledge, namely with philosophical enquiries in nursing. These are at present somewhat arbitrary, certainly ill-defined, often misleadingly superficial and generally, perhaps wisely, ignored by both nurse theorists and practitioners. The urgency with which at least some nurses are searching for valid and reliable knowledge appears to be largely directed towards establishing a very narrow and it seems to me, potentially dubious 'science' of nursing. Both the unsatisfactory, confusing state of nursing philosophy and the fragmented approach to a limiting nursing science may be related to the inability of many English-speaking nurse theorists and writers to conceive of different kinds of 'knowledge' set in a wider context than that of a narrowly defined 'science'.[1]*

* arabic figures refer to notes which follow each part

Knowledge in the sense in which much of the nursing literature presents it, is concerned with facts, their relationships, their causality and their effects. Nursing knowledge at present is largely disconnected and disjointed, and I would fear will remain so, because it lacks form and structure as a whole. It is perhaps not just coincidence that the German word '*Bildung*' derives from the word '*Bild*', meaning a picture. A picture has a form partly imposed by its frame, partly by its subject matter. The latter, along with the chosen technique of representation, will influence its structure. Nursing lacks a consistent framework, is uncertain of its subject matter and often uses techniques of representation arbitrarily and randomly.[2]

'*Bildung*' denotes a process by which an individual acquires coherent, comprehensive, integrated and conceptualized knowledge about the world.

Here two other German words would be useful to draw an important distinction. '*Bildung*' should be the process which leads to a '*Weltbild*' but not necessarily to a '*Weltanschauung*'. Part of the process leading to a '*Weltbild*' consists of the acquisition of knowledge but being knowledgeable is not enough. '*Wissen*' (i.e. knowledge) is not the same as '*Bildung*' (i.e. coherent, integrated and conceptualized knowledge).

The possession of '*Bildung*' allows the individual to develop a coherent and integrated view of his or her world leading to a consistent '*Weltbild*' (i.e. a picture or an image of the world).

To construct a picture of one's world as it might be rather than as it is, to invest in certain values by which one would endeavour to change one's world in certain ways or by which one would endeavour to preserve those features of it which are consistent with one's values, would lead to an ideological conception of the world or to a '*Weltanschauung*'.

Following this line of reasoning one might argue that just knowing some things in or about nursing is not the same as nursing knowledge and that a conceptualization of nursing is not identical with a nursing ideology.

Furthermore, some knowledge in the narrower sense of '*Wissen*' may well be 'right' within an accepted mode of enquiry rather than that it expresses some relevant or valid truth about nursing. This distinction between what may be 'right' rather than 'true' might again be more readily appreciated if I could use the language of a German philosopher of science, Haeckel, who contrasted '*Richtigkeit*' with '*Wahrheit*' in the context of nineteenth century natural science research. In a very simple way one might illustrate the difference between '*Richtigkeit*' and '*Wahrheit*' by examining a statement which involves numerical concepts and a simple arithmetical method. If I say, "There are 10,000 nurses in a hospital all working a 60 hour week therefore providing 600,000 hours of service per week", I have made a statement which is right in the context of arithmetic but which cannot be true in the context of nursing since there is no hospital with that many nurses who all work such long hours.

It might still be a useful statement for someone who is learning arithmetic since the '*Richtigkeit*' of its mathematical content would be the primary concern of the person who made it. It would obviously be of no use to a nurse manager in predicting budgetary needs since its '*Wahrheit*' in nursing is rather doubtful. This distinction seems to be a useful one to remember when nurses voice some disenchantment with the results of certain kinds of nursing research.

> "Within the nursing profession there has been undue reliance upon theoretical constructs borrowed from other disciplines and uncritical acceptance of them - both with regard to their inherent validity and to their usefulness in explaining and making reliable predictions about the complex phenomena encountered in nursing practice." (Schlotfeldt 1971)

This comment by a nurse appears to point to the distinction which I consider important here: an investigation may well be 'right' in the terms of the discipline in which it is carried out without holding any 'truth' for nursing.[3]

It is necessary for knowledge to be placed in, and to be illuminated by, a context which perhaps might best be described as humanistic. One feature of the European humanistic tradition expressed in the notion of '*Bildung*' is more than a passing acquaintance with the contributions of philosophy to the understanding of our world.

One concern that has led me to writing this thesis is that nurses by and large do not understand their world, i.e. nursing. A second concern arises from the first. Many nurses wish to create a picture of nursing by intensive 'scientific' investigations.

It seems that the narrowness of 'knowledge' in nursing is reflected in the often limited sense in which the English word 'science' is used.

Chalmers (1978) suggests that statements like

> "Scientific knowledge is proven knowledge. Scientific theories are derived in some rigorous way from the facts of experience acquired by observation and experiment. Science is based on what we can see and hear and touch, etc. Personal opinion or preferences and speculative imaginings have no place in science. Science is objective. Scientific knowledge is reliable knowledge because it is objectively proven knowledge." ,

sum up what is essentially a modern, naive inductivist account of 'science' which is not only wrong but dangerously misleading.

Williams (1976) provides an account of how the English word 'science' came to be used specifically and exclusively to denote

> "the successful methods of the natural sciences, primarily physics, chemistry and biology. Other studies might be theoretical and methodical, but this was not now the main point; it was the hard objective character of the material and the method ... which was taken as defining."

The problems created by this specific and exclusive use of the word 'science' are mainly that the methods of physics, chemistry and biology are seen to be the only methods of all the sciences and that 'knowledge' comes to equal 'science' which equals 'the scientific method', so that anything that can be known at all can only be known by the methods of the empirical, experimental sciences. (Putnam 1978)

In contrast to the now prevailing limited sense of the word 'science', the German word '*Wissenschaft*' which is commonly translated as 'science', has a much less restricted meaning

since it denotes any body of organised knowledge that has been acquired in a systematic manner by quite different methods of enquiry. The harm that a very narrow concept of what constitutes 'science' inflicts is primarily that it casts doubt on the legitimacy and respectability of any form of human enquiry which does not fall within its definition.[4] If nurses allow themselves to be confined to the apparently more legitimate and more respectable 'real sciences', they will fail to explore many important aspects of nursing and they will limit rather than extend the understanding of what nursing is or might be. Philosophy presents such a body of organised knowledge outwith the narrowly defined 'sciences' which it has acquired by methods quite different from those employed by 'real scientists'.

Whether or not it is due to the generally narrower concept of knowledge or the limited conception of science, nurse theorists generally shy away from philosophical enquiries. Whether or not the lack of wider concepts such as '*Bildung*', '*Wissenschaft*' and '*Wahrheit*' also excludes the possibility of becoming more thoroughly familiar with current philosophical concerns and approaches than many nurse writers appear to be, when 'philosophy' does make an appearance in the nursing literature, it frequently denotes subjects and activities which are not necessarily the philosopher's domain, nor the only concern of philosophical enquiry.

This thesis is an attempt to present an argument concerning the meaning and relevance of philosophical enquiries in nursing.

It must therefore largely ignore many aspects of philosophical debate and must deliberately focus on what Winch (1958) calls the "underlabourer conception" of philosophy in the service of other enterprises.[5]

The main point of the argument is that nurses are engaged in a search for knowledge, that philosophers have certain kinds of knowledge and demonstrable ways of acquiring them and that nurses on occasions attempt to utilize these for their own purposes. But they very often do this badly. To utilize philosophical enquiries more effectively, nurses must cease to be arbitrary, subjectively selective and superficial in their concerns with philosophical issues or their misuse of what philosophy may have to offer will continue to produce largely irrelevant, confusing and distorted results. The misuse of philosophy in nursing can only be remedied if nurses can conceptualize the potential development of nursing knowledge, if they understand more clearly the nature of philosophical enquiries and if they can develop a consistent approach to philosophical issues in nursing.

This argument does not start by posing *a* question, nor even a series of questions but by stating some possibly logically related assumptions. It does not regard these assumptions as irrefutable or inviolable, but rather as a *starting point* for the enquiry.

In the pursuit of this argument, many questions will be raised. Some may be amenable to further philosophical enquiry,

others may be of a kind that should be subjected to 'scientific' investigations. It may well be that the questions that are already implied in the outlined argument are not the most important ones to ask but that others emerge which turn out to be far more crucial. I believe that one does not know necessarily at the outset of a philosophical argument what is crucial, and that this is an essential feature of this mode of enquiry.

I have considered carefully the form of the presentation of this argument. The style, form and structure of philosophical treatises vary considerably with the topic in hand, with the philosophical tradition that a writer prefers and feels most comfortable with and reasonably competent in emulating, and with the audience who is invited to share in the argument.

I would like to think that an old tradition in philosophical discourse still demonstrates one of the fundamental methods of philosophical enquiry: the conversational method of argument involving question and answer which is described by the Greek word 'dialectic' meaning 'to converse' or 'to dicourse'. It appears to me appropriate in the context of this argument not only because it avoids the complexities and pitfalls of more formal presentations but also because it demonstrates directly some important characteristics of a philosophical enterprise.

A philosophical argument of that nature is an individual and personal statement, and although following certain rules and conventions, it should never pretend to an objectivity or

neutrality which is foreign to it. The work and the writer are not external to the task as tools or observers. The writer must question and take issues with the work as it proceeds, in the same manner in which this would be done by a thoughtful conversational partner.

Campion (1979) showed in an imaginative and compelling way that the "manner of dealing with the materials around us displays our efforts to continue thinking as we do." Although greatly influenced by Campion's work, I shall in no specific way emulate his approach, much as I admire it as a resolute realization of the dialectic method. This may certainly be partly due to my limitations, but partly is a consequence of what I consider to be the individual and subjective nature of this form of enquiry. I shall try to follow Campion's example "to listen thoughtfully to what we have been, and are saying as we continue writing." But I need to say it in my own way. I shall in the absence of a conversational partner conduct what might best be described as an 'inner dialogue'. Unlike Campion who could transform himself into the 'we' of the opposing sides of the argument, I shall relate my thoughts as 'I', since I feel intellectually and emotionally incapable of representing different personae. But direct and personal speech will be used as the proper medium of a dialectic discourse.

Dialectic reasoning often emphasizes the importance of questions over the possible finality of potential answers.

> "There can be nothing 'clinching' in philosophy: 'proofs' and 'disproofs' hold only for those who adopt certain premisses, who are willing to follow certain rules of argument, and who use their terms in certain definite ways. And every proof or disproof can be readily evaded, if one questions the truth of its premisses, or the validity of its type of inference, or if one finds new senses in which its terms may be used." (Findlay 1949)

Vesey (1972) warns his readers that "Philosophy is not a spectator sport". I wish to encourage the reader to participate in the argument.

It is in many ways essential to the whole argument as well as to the question of participation that it must draw the distinction between the use of scientific knowledge in its narrower sense, and the ways in which philosophy may be of use, in nursing.

One major difference is that nurses may well use the results of scientific enquiry without participating in or repeating the experiments or observations which have produced these outcomes. In philosophical enquiries it is essential that nurses participate in the enquiry.

One regrettable limitation to the chosen format of presentation has already been mentioned, i.e. my inability to produce literally a dialogue which would come nearest to the real essence of a dialectical discourse. I would go further and argue that the most effective and convincing philosophical activity lies in a face-to-face verbal exchange. However, this limitation offers one opportunity which neither a 'real conversation' nor a reconstructed dialogue would easily permit. I shall deliberately indicate sources of information and knowledge probably beyond the usual expectations in a philosophical work.

The reason for this is threefold. Firstly, my argument is largely based on what I claim that philosophers say they do. It might be appropriate to substantiate my claims in this respect to some extent. Secondly, nurses often (if mistakenly) feel that philosophical discussions do not refer to or utilize verifiable facts. It may be opportune to demonstrate that this assumption is not true. Thirdly, although I agree with Campion that "thoughts aren't worth having, if by having is meant possessing as property; and private property at that", I do not wish to claim as my thoughts what I have gained from others. Thinking is worth doing both with my thoughts and those of others who shared them with me as I am prepared to share mine with others. If we did not do so, we "would be allowing ourselves to be possessed by facts the true value or virtue of which we had not inquired about", as Campion rightly points out.

I shall only consider this argument to have been worthwhile, if I can genuinely recognize and own up to the fact that I am at a loss when either a question, a possible answer or an anticipated progression elude me. But I fully agree with Campion that "genuine inquiry ... does not settle for what it imagines it already knows it can stand but ... chooses to extend itself."

NOTES TO THE INTRODUCTION

1 The concept of 'knowledge' has raised numerous and complex philosophical questions which usually are dealt with by either epistemologists or by the philosophers of mind. Epistemological questions rather than those concerning the nature of the knowing person's mind underlie this argument here. The search for knowledge as an objectively ascertainable certainty and as an indivisible entity whether in a Platonic or Hegelian form has had many critics. Although the apparent objectivity of Plato's forms and the rationality of Hegel's historical dialectic have been shown to lead to an infinite regression of proof, the twin notions that there is only one kind of 'real' knowledge with an ascertainable degree of objectivity have by no means disappeared. It is against this conception of knowledge as something indivisible and as an homogenous whole that I would wish to argue. Epistemological endeavours are now mainly concerned with explanations of the many particular kinds of knowledge and with their canons of proof and acceptability. Hirst's proposition (1974) that there are different forms of knowledge and awareness such as the empirical, the mathematical, the philosophical, the moral, the aesthetic, the religious and possibly the historical/ sociological with their own distinctive tests for truth can be taken as a point of departure in my argument. A searching analysis of Hirst's position which is beyond the scope of this work is provided by Brent (1978).

2 A passing reminder by one of my supervisors that the German word '*Gestalt*' is not directly translatable into English either made me aware of its potential likeness to what I wished to convey by introducing the word '*Bild*' into the argument. A standard explanation of '*Gestalt*' as offered by Flew (1979) as an organised, coherent whole whose parts are determined by laws intrinsic to the whole rather than being randomly juxtaposed or associated, would certainly bring out its opposition to the atomistic empirical tradition which I see to be dominating a great deal of nursing research. I would suggest, however, that '*Gestalt*' implies a dynamism in a visual, perceptual and interpretative process in which 'seeing' is essentially a phenomenological creation in so far as what is 'seen' is what appears to the seer rather than what may actually be there. Apart from the fact that '*Gestalt*' has become a central concept in a specific psychological theory and using it in this context here may lead to expectations with which I cannot deal in my argument, I also feel that the word has a more pressing quality and a less descriptive connotation than the word '*Bild*'.

3 The concepts of 'validity' and 'reliability' which are central to any research endeavour come to mind here. They do not, however, express precisely the point which I am trying to make. Let us assume that a piece of social science research is valid in the sense that the questions asked or hypotheses posed are legitimate sociological concerns and that the methods employed yield data which are relevant and lead to answers or proofs which are acceptable to sociologists. Let us further assume that the chosen methods yield consistent, accurate and precise data. Such a piece of research would be both valid and reliable. Nevertheless, although being 'right' as a piece of sociological research, its hypotheses, methods, data or proofs may not be either valid or reliable in the context of nursing. It may not pose questions or hypotheses which are derived from a conceptualization of nursing (and indeed as a piece of sociological research one would not expect that it does so), its methods when applied to nursing questions may yield inappropriate or irrelevant answers, and any replication of the enquiry in nursing may produce unreliable results. The fundamental issue here is, I believe, that 'validity' and 'reliability' are intradisciplinary judgements to decide whether an investigation is both right and true within the terms of that discipline. The knowledge that is the result of a valid and reliable investigation may well be of use to other disciplines but this does not necessarily mean that other disciplines would endeavour to identify and create their own knowledge in exactly the same way.

4 The effects of scientism (i.e. the belief that 'real knowledge' can only be acquired by the methods of the empirical sciences) range from the strangely anthropomorphic notion of a 'mature' science (like physics) to the many areas of study which are described and 'defended' as 'sciences' by their supporters, presumably in an effort to regain the confidence and respectability which appear to have been taken from them. So it may come about that some historians now refer to their subject as 'historical science'. Disciplines which developed after the natural sciences were elevated to a kind of prototype of all forms of legitimate human enquiry, tend to aspire to the accolade of being considered 'scientific'. Political science and social science are now commonplace. But it would be misleading to think that this apparently extended use of the word 'science' denoted a return to its original meaning derived from the Latin word '<u>scientia</u>' meaning simply 'knowledge'. The claim of these disciplines to be 'sciences' is not based on some inherent worthwhileness of their endeavours justifiable in their own terms but on the degree to which they can emulate the natural sciences in their methods. Chalmers (1978) tells of the inscription on the facade of the Social Science Research Building at the University of Chicago which reads, "If you cannot measure, your knowledge is meagre and unsatisfactory." It seems a small step from this mistaken

assertion to the world of advertising where a product is said to be superior to its rivals by having been subjected to 'scientific tests' showing it to be whiter, brighter or more potent.

5 Winch's critique of defining philosophy *only* in terms of what it may contribute to the clarification and to the solution of problems in other disciplines appears to me to be justified. His main aim is to demonstrate that philosophy *can* be distinguished from other arts or sciences by its subject matter and not only by its methods, that it has problems of its own and that it does not *only* provide "a technique for solving problems thrown up in the course of non-philosophical investigations." But in doing so, he does perhaps inevitably, ignore the *essential* contributions of philosophical enquiries in the service of other disciplines. Without denying that philosophy deals with its own germane problems, but also without attempting to prove or disprove the assertion that philosophy has a subject matter of its own, the whole purpose of my argument is to examine in what way, if any, philosophical enquiries may be relevant to and meaningful in nursing. If the phrase 'philosophy of nursing' had not been so terribly misused (by nurses) and had therefore become rather suspect to me, I would be satisfied, if my argument contributed to a genuine 'philosophy of nursing' in the same way in which a philosopher-historian may contribute to the philosophy of history or a philosopher-scientist to the philosophy of science.

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PART ONE

THE JOURNEY

The search for nursing knowledge, its practical, professional and academic purposes; criteria for different aspects of nursing knowledge leading to the relationship of the forms to the contents of the new knowledge; conceptualizing nursing in order to identify new nursing knowledge; sources of knowledge for nursing including irrelevant, arbitrary and inappropriate selections; the arts in nursing and the art of nursing reconciled; questions of substance and syntax leading to infrequent, fragmented and confusing attempts at explaining the nature of philosophical enquiries in nursing.

THE JOURNEY

"... nursing is now an anxious profession", claims an American professor of nursing. (Schlotfeldt 1975) I would argue that nursing has always been a worrying profession. I believe this to be true in two senses. Nurses have, since the days of Florence Nightingale, always worried about the nature and purpose of nursing, about their tasks and functions, about the most effective way of preparing nurses, and about the relationship of nursing to other caring groups, especially to medical doctors.

The establishment of nursing as a formal occupation in the mid-nineteenth century in the United Kingdom was in itself the outcome of another kind of worry about nursing. Those who required nursing, or people who spoke and acted on their behalf, demanded a better service of the kind that nurses were considered best suited to provide for society.

Neither the worry of nurses about nursing nor that of others about nurses and nursing has ever ceased and occupies the profession to this day in almost every country in the world. But the focus of nurses' concerns has changed in some ways which are significant for this argument. While the public continues by and large, to demand more nurses and better nursing services in terms of numbers, distributions, enticements and rewards, nurses themselves have introduced a new aspect to the debate about nursing. The suggested solutions to the problems which apparently beset the nursing profession in the first half of this

century concentrated largely on the need for recruiting, training and retaining more nurses. (Baly 1973) From the 1950's onward, the demand for more nurses was frequently accompanied, if not entirely replaced, by a strongly expressed desire for *a new knowledge in nursing*. To have and to hold more nurses as such appeared no longer, especially to nurses themselves, to be the only solution. If more nurses were needed, they also needed to be different.

Here, a question that may be answerable by a critical historical enquiry comes to my mind in perusing the literature from which I have formulated the above assertions about the two kinds of worry about nursing.

It may well be that nurses themselves have always been more concerned with rather more fundamental questions about the service which they are expected to provide than the reports of the first half of this century seem to indicate. It is only since 1941 when the Royal College of Nursing set up the Nursing Reconstruction Committee which reported between 1942 and 1949 that nurses have been represented in greater numbers on committees and working groups which set out to examine nursing nationally, or that enquiries of this nature have been set up by nurses themselves. (Baly 1973) It may be instructive to compare briefly two reports which were not too distant in time from each other.

"A Reform of Nursing Education" (the Platt Report) was published in 1964. Over 62% of the committee members were nurses. "The Staffing of Mental Deficiency Hospitals" (the Batchelor Report) was published in 1970. In a membership of ten, only one nurse qualified and experienced in the care of mentally deficient people served on the committee. While the Platt Report could say that

> "the nurse must ... assume the responsibilities of leadership ... adopt a critical approach to her work and ... adjust to changing conditions...",

the Batchelor Report concluded that the extension of the nurse's functions "towards education and training ... and ... towards a greater degree of participation and even leadership ..." is not desirable and that it had not been possible "to identify any techniques of nursing which are peculiar to this field of work." One may wonder what influence a reverse ratio of nurse representation on these committees may have had on the conclusions which were reached, if one assumes that nurse members *may* have been more concerned with rather more fundamental questions about *nursing* than non-nurse members.

In any case, in "A Reform of Nursing Education" the hope that the study of nursing would become a suitable subject for study at university level was expressed for the first time in a published report.

The "Report of the Committee on Nursing" (1972) reaffirmed on a broader basis this new look at nursing and demanded that efforts should be directed towards making nursing a more research

based profession. It was no longer felt to be sufficient for the education of the professional nurse of the future to "remain at the level of a training in procedures". Such skills as nurses may acquire have "to be supported by a rationale, a scientific basis for action". A theoretical basis for nursing action, well-founded in scientific principles, many writers agree, is essential to the provision of effective nursing care. Although nurses are as yet in the early stages of theory construction and are still engaged predominantly in the endeavour to describe what actually happens in nursing, the search for a new knowledge in nursing and the efforts to "see nursing in a new light" (McFarlane 1976) have become declared aims of many nurse writers and theorists.

Here, I feel that I must pause and consider what the foregoing part of the argument has established. Apart from a speculative diversion which does not appear to be fundamental to the general trend of thought, I have stated *a fact*, that is, an observable and even measurable phenomenon: nurses are saying that they need a new knowledge. But a fact as such is worthless.[1]

I can also state the fact that the land area of Scotland covers 29,798 square miles. What might make this factual statement interesting, useful, amazing, or boring is the response that it evokes in the listener who attaches a particular meaning to it, and not necessarily the same meaning as other listeners might do. It is also feasable that a listener shows no response at all to this statement of fact.

To be able to respond at all, the listener must be numerate and must have some idea what sort of land area constitutes one or ten or one hundred square miles. In other words, he must be able to conceptualize to some extent what this verbal statement means. How he responds to the meaning of this fact will depend on the context in which he chooses to put this item of factual information.[2] A land surveyor who is about to set up a plan of work might find the information useful in deciding how many people he should engage and for how long. A sheep farmer might want to know how much of this land is grazable before he considers this fact to be of any interest to him. A traveller might simply be amazed or disappointed to find that Scotland is so large or so small, depending on her previous assumptions and on her experiences of travel.

'Nurses need a new knowledge' is a statement that acquires its meaning by the particular response which it evokes in the listener. It is a complex statement and it could elicit any number of responses. The response may initially depend on the word which appears to stand out for an individual listener: nurses, need, new, or knowledge.

My immediate response is to the word 'new'. This may indicate that, as a nurse, I assume that nurses have already some knowledge that is needed in some way or other, but that I am puzzled by the demand for 'new' knowledge. Why do nurses need a new knowledge?

Henderson (1966) in quoting a government report, offers as a reason that a "body of knowledge (is) needed as a basis for the improvement of nursing care". Scott Wright (1973a) sees "a deep and broad enough range of knowledge" as a means for the nurse to function effectively. McFarlane (1978) considers it axiomatic "that the art of nursing consists of actions of a nursing nature which are informed by knowledge or science". Without knowledge, she asserts, the "quality of practice degenerates into routine or sentiment and becomes unsafe". She goes further by indicating a moral duty for the nurse to use "available and relevant knowledge" and describes a nurse who fails to do so as "guilty of negligence".

Not all writers emphasize primarily the need for knowledge in the context of greater nurse effectiveness, that is, leading to improved patient care.

> "Much lip-service is paid to the idea that nursing is a profession, yet all writers on professions and professionalization insist that an essential hallmark is the possession by the occupational group of a specific body of knowledge ..."

writes Chapman (1972), and she continues, "Nursing may or may not possess this body of knowledge". The status that knowledge confers on a group of people who hold this knowledge in common but do not share it to any great extent with others who do not belong to this group, and who develop a distinct identity that distinguishes them from other similar groups, is clearly referred to by Rickelman (1971). She feels that

"we are closer now than ever before to formulating and synthesizing a body of knowledge which ... will serve to conceptualize nursing's functions in a systematic structure of knowledge differentiated from the functions and structure of knowledge of other health disciplines."

In examining ideologies in nursing, Williams (1974) expounds the idea that

"Then, as now, doctors have a monopoly of knowledge relating to disease and its treatment, and nurses' work is regarded as being in the service of this knowledge ...".

However, there is again an implication that knowledge of a particular kind is some kind of possession which identifies a group of people and increases their status vis à vis those who do not have a similar possession. Nurses' work serves the group (or even groups) of people who claim knowledge that is distinct from theirs, is not shared by them, and is organized in a particular way. It may also be considered to be superior in some way.

Another trend of thought is that the knowledge which nurses need (or need to develop, or already have in some form), should serve to establish nursing alongside other academic disciplines which are "... seeking recognition as applied scientific disciplines developing their own identifiable area of knowledge and expertise ..." (Scott Wright 1973b). Zbilut (1977), concurring with this view, says,

"One of the major challenges still facing nursing as a profession is the development of a body of (knowledge) which would be recognized ... by the academic community ..."

Some nurses whose main work is the gathering of knowledge may

"even adopt values which supplant the service to society value which underlies nursing ... A value of knowledge for the sake of knowledge is one that is commonly expressed",

comments Ellis (1970) who sees the nurse scientist as being estranged from the nurse practitioner, and as being motivated for different reasons to make the search for knowledge her career. She suggests that the motivation underlying this choice may be

> "The seeking of answers, of knowledge, of status or prestige, of power or influence, of enjoyment, or of special skills ... There are probably many more motives, such as avoidance (of the practice of nursing)."

So what nurses are saying is that new knowledge is needed for many different reasons, such as improving nursing practice, raising the status of the profession, establishing nursing as an academic discipline , and gaining knowledge as an end in itself.

Some people, however, feel that not all these reasons are valid.

Not everyone agrees that nurses need a new knowledge in order to provide more effective nursing care. Few *nurses* disagree with the assumption that more or new knowledge could improve the care that they give to patients, but occasionally a nurse dissents from this view. Although

> "... nurses may happen to have a private interest of their own in biology, poetry, politics or whatever, ... it seems to me quite unrealistic to wish on all nurses a smattering ... of general knowledge with the pretensions of a 'study in depth'",

and

> "Do we really ... have to formulate theories before we can get down to work?"

asks Graham (1972).

The search for knowledge in nursing is questioned more often by members of other professions. A doctor speaks of "the wall of incomprehension" which the determined advances in nursing knowledge may encounter on the part of the medical profession. (Jacobs 1970) He regards the "over-evaluation of intellectual achievements as dangerous to ... society" and fears that "professionalized intellectualism" may reign supreme. He is clearly concerned that the intensive preoccupation of nurses with knowledge is a "status symbolism of a 'white-collar level of thinking' (which) may pose problems ..." for nurses, doctors and patients. Nursing care might, in fact, become less effective, if a "do-nurse" and a "think-nurse" are created in the process, a concern which is shared by Graham who imagines the

> "nightmare situation in which teams of graduates are deployed in devising measurement tools and exercising their research techniques in assessing quality of patient care given by two teenage student nurses in a ward of 40 bed-ridden old people."

Far from seeing the search for knowledge as a means to improve nursing care, Jacobs regards

> "the acquisition of more knowledge ... as a choice in favour of the road of least resistance; as a defence mechanism against the true problems and needs ... (and) the 'badge-hunting' and rush for certificates of some nurses as a sign of intellectualization, and as a defence against the problems of true womanhood."

But there are also warnings from within the nursing profession to consider carefully what is good for nursing as opposed to what is good for the prestige of nurses as an emerging profession. No amount of knowledge (gained in 'higher education') "which blows up the prestige of the nurse, and sometimes does precious

little for the consumers of nursing will establish the status of nurses as members of a profession." (Lamb 1970)

There are others who doubt that nursing can establish itself as an academic discipline by developing academically creditable knowledge.

> "Academic study ... can only be discipline based - and an academic discipline comprises a body of knowledge informed by research and built up over time - whereas nursing is a skill - a practical art - informed certainly by a number of disciplines ... but incapable in its own right ... of developing as a separate discipline." (Evans 1975)

And finally, knowledge for its own sake has its critics, too. McFarlane (1978) feels that "knowledge which is amassed for intellectual kicks and without relevance to practice adds little to the art of nursing".

What has my response to the question 'Why do nurses need a new knowledge?' produced? I have found evidence that nurses claim knowledge for a variety of reasons and purposes which are not all seen to be equally valid, or in a few instances, are not considered to be valid at all. I must dismiss the latter assumption from my argument. Not only because it would have to be concluded rather prematurely, but also because I claim the right to support the most frequently voiced reason for the acquisition of knowledge, namely that more (or new) knowledge might improve patient care.

I cannot see it as wholly problematic that some knowledge in nursing may be searched for and perhaps found for different reasons.

If such knowledge becomes available to nurses who consider it relevant to nursing practice, there seems to be no reason that they could not use it in their endeavours to provide more effective nursing care.

If I had been given a great deal of money as gifts from good friends who were engaged in making money for many reasons of their own (to improve the lives of people, to gain respect and power, to become a member of an exclusive club, or just to make money), I could still spend this money for my own purpose. I could improve my health, buy prestigious possessions, join expensive gatherings of people, or put it into a bank.

I realize that my comparison should include the possibility that my potential benefactors had amassed their fortunes in foreign currencies which would not allow me to do any of these things.

Similarly, knowledge that is primarily gained for purposes other than its direct application to nursing care, may be of no use to nurses. The disenchantment experienced by nurses in this situation has already been commented upon.

But I shall still hold open the possibility that we cannot really decide what kind of knowledge will turn out to be valid or invalid in a nursing context until that context has been defined.

There is, however, no indication in my evidence so far, why nurses need *new* knowledge or what particular kind of knowledge the

writers have in mind. In the previous pages it has been described as

- a body of knowledge (informed by research)
- a range of knowledge
- knowledge or science
- available and relevant knowledge
- specific knowledge
- a systematic structure of knowledge
- a monopoly of knowledge
- an identifiable area of knowledge
- general knowledge
- more knowledge

These terms do not make explicit by what criteria this knowledge might be identified.

A further reading of the literature reveals that this knowledge, described in similar terms to those listed above, demands

> "a grounding in the physical, biological and social sciences, and the ability to use analytical processes ... (without which) the student of nursing cannot acquire a systematic knowledge of human behavior and development, of group behavior, and of therapeutics ...". (Henderson 1966)

"... courses (must) provide students with a scientifically based and conceptually whole body of knowledge" (Editorial 1974), which is also described as "formidable". (Wilson 1964) This

> "evolving body of knowledge essential to the practice of nursing will constitute a synthesis of knowledge from other disciplines, but hopefully this synthesis will be unique to nursing,"

explains Rickelman (1971), and Scott Wright (1973b) expects that nursing will develop knowledge "based on yet older academic

disciplines including the liberal arts, physical, biological and behavioural sciences". This "infinite need for knowledge (especially) of the biological and social sciences" (Henderson 1966) is reflected in "increased theoretical thinking" and

> "There is much emphasis today on defining and discovering the knowledge which is essential to research, teaching and practice." (Rickelman 1971)

All this is perhaps aptly summed up by Gordon & Anello (1974) who envisage that

> "... the nurse must not only master the traditional professional content (of the curriculum), she must acquire a more intricate body of knowledge ...".

It appears to me that the terms which are used to describe this knowledge that nurses should have, imply certain criteria which refer to different aspects of it.

1. There are terms which refer primarily to the *form*, *structure*, and *organisation* of this particular kind of knowledge: a body, a range, a systematic structure, an identifiable area, a conceptually whole

2. Other terms appear to define its *nature*: infinite, scientifically based, belonging to or taken from the physical, biological and social sciences, and the liberal arts

3. Still other terms tell us something about the *expectations of the owners or users of this knowledge*: available, relevant, specific, a monopoly

4. The phrase "informed by research" probably indicates *how it should be obtained.*

5. There are also some indications of *what its owners or users should do with it*: define and discover, engage in theoretical thinking, analyze and synthesize

6. There are words which refer to the *relationship between this new and other knowledge* that nurses already have: it is different from the "traditional professional content", it is "more" and more "general"

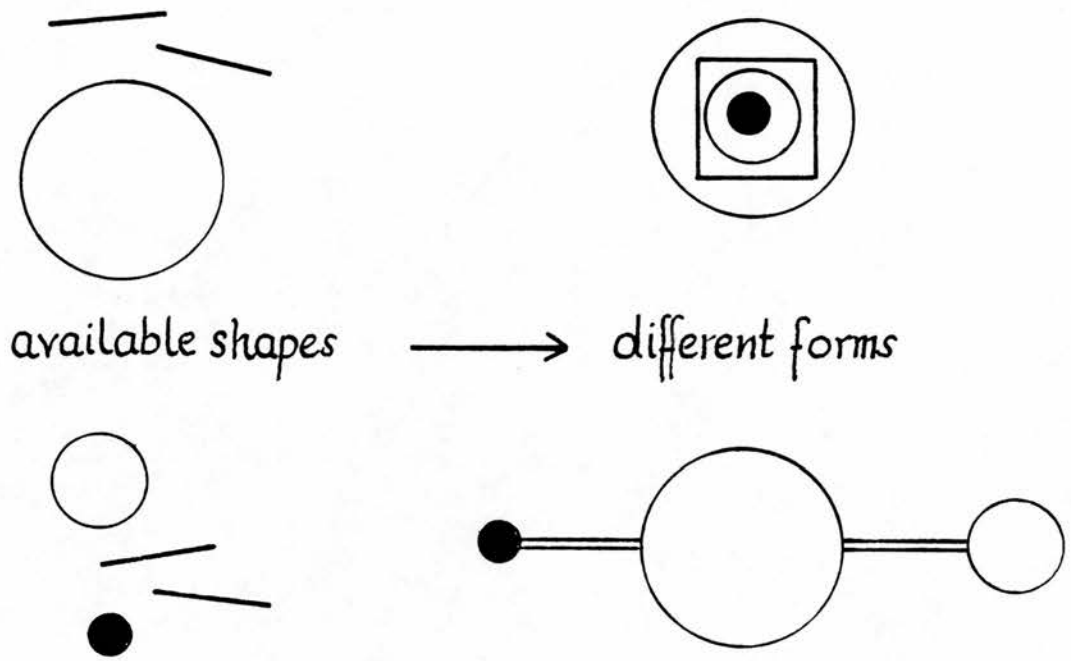
In my argument, I shall refer to these different aspects of nursing knowledge as

1. forms
2. contents
3. expectations
4. methods of enquiry
5. uses
6. relationships

It seems essential to distinguish clearly between these various aspects to avoid some of the confusions which can only make a complex issue less amenable to clarification.

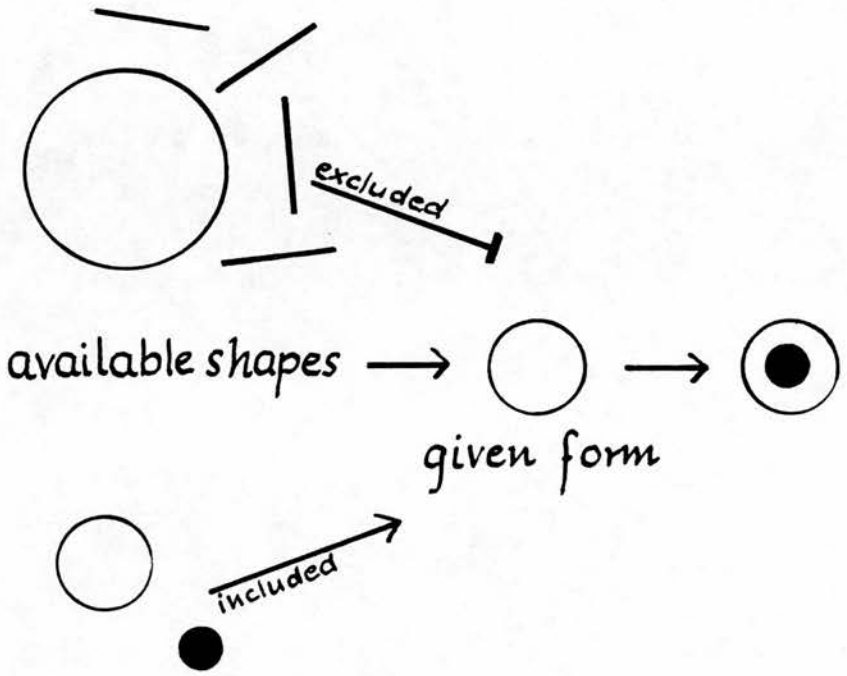
To take an example: the word 'specific' occurs often in the phrase 'a specific body of knowledge'. If a 'body of knowledge' refers to the potential or actual forms of this knowledge, as I think it does, then a degree of specifity is inherent in the process of systematizing material of any kind.

Forms are made specific by the components which shape them, or a given form may take in or be filled with specific components which happen to fit into it. In other words, either the components to be structured will produce a specific form or more likely, a number of specific forms, as might be illustrated by making forms of various available shapes thus -



or an already given specific form will allow certain available components to be fitted into it, while others remain excluded, as might be illustrated by selecting those shapes which will fit

into one form thus -



Which of these two possibilities of structuring nursing knowledge should be used may be a very crucial question. But in either case, the result will be that a body of knowledge *must* be specific by definition, whether it derives its specifity from the components of knowledge to be structured or from its predetermined form. To use the adjective 'specific' in the sense that the forms which nursing knowledge may take, must be 'specific', results in a tautology.

It is more likely that the use of the word 'specific' in the phrase 'a specific body of knowledge' refers not to its form but to one of the other aspects of nursing knowledge. From the context of the article from which this phrase was taken, it seems

that 'specific' referred to an expectation, namely that this formalized knowledge should belong specifically to nurses. It could, however, in other contexts refer also to the contents, the methods of enquiry, the uses, or the relationships of this knowledge.

The phrase 'an infinite need for knowledge' provides another example of the necessity to try and identify to which aspect of nursing knowledge a word like 'infinite' might refer.

Forms, by definition, cannot be infinite.[3] Forms of knowledge are characterized by a particular range of knowledge that either fits into or produces them. Forms, structures and organisations imply boundaries. Therefore an 'infinite need for knowledge' cannot refer to a need for infinite forms of knowledge.

An infinite content might be feasable if one allows that forms may have an infinite number of components (or sets an infinite number of members).

Infinite expectations, however, contradict the expressed desire that this knowledge should be specific to nursing. The use of all known and still to be known methods of enquiry might perhaps be described as infinite, but the uses of knowledge, however it has been acquired, are probably limited, if that knowledge is to serve specific purposes. The relationship of this new knowledge to other forms of already existing nursing knowledge is unlikely to be infinite.

The alert listener may well point out that Henderson talks about an "infinite need", not about infinite knowledge. I would offer the suggestion that the whole endeavour to identify, define, conceptualize, circumscribe and structure nursing knowledge indicates processes which must direct and channel the need for knowledge, however great, in specific ways and therefore would make it less than infinite.

But to recall that nursing may or may not possess this kind of formalized knowledge does not make the task of identifying it any easier.

If I assume, as some writers do, that this knowledge does not exist at present, I have to leave aside for the time being the expectations, uses and relationships of nursing knowledge. It appears that expectations of something, and its use, depend on having or obtaining it in the first place. I would also argue that one cannot demonstrate a relationship between something that exists and something that does not exist.

I am therefore left with the *forms*, *contents* and *methods of enquiry* of a kind of formalized nursing knowledge that needs to be created.

In what way are these aspects related to each other? I would like to go back to Rickelman's statement,

> "we are closer now than ever before in formulating and synthesizing a body of knowledge which ... will serve to conceptualize nursing's functions in a systematic structure of knowledge ..."

and compare it with an explanation offered by Henderson (1966)

> "... the analysis of the nurse's clinical experience ... is the way to develop nursing (knowledge)".

If I understand Rickelman's statement rightly, she is saying,

1. we are producing the *forms* of knowledge
2. these will lead to a *conceptualization of nursing* within these forms

While Henderson says really the opposite,

1. we should *conceptualize nursing* through an analysis of the nurse's clinical experience
2. this will lead to the *forms* of knowledge.

These statements are trying to relate the forms to the contents of nursing knowledge. This, as I had already anticipated, is one of the most crucial relationships to be examined in the endeavour to identify the nature of that knowledge for which nurses are searching.

The process that is advocated by Rickelman resembles the first model or representation of the construction of forms which I offered earlier on.

Components or parts of knowledge will be structured in a particular way to produce a specific form of knowledge. But the point which I tried to make was that this process is likely to result in *a number of specific forms*, and not only in one. If, as Rickelman argues, nursing will be conceptualized within these forms (and it is significant that she uses the plural in this

context), then not one, but *a number of conceptions of nursing* must emerge. There may be good reasons to argue that not all nurses are engaged in the same kind of care, and that, for example, general nursing differs conceptually from psychiatric nursing. But if this were the case, that is, *a fundamental difference in the nature of the caring activities* engaged in by general and psychiatric nurses could or should be demonstrated, then I believe that the same word to describe these fundamentally different activities, namely 'nursing', should not be used in both instances.

Although Toulmin (1972) holds that a concept is something that everybody uses but nobody explains and still less defines, he does suggest that it has something to do with how we structure our experiences and with how we categorize entities with which we have to deal.

Wilson (1963) expresses a fairly general notion when he maintains that there is, strictly speaking, no such thing as *the* concept of anything. But he also admits that

> "when we talk of 'the' concept of a thing, we are often referring in an abbreviated way to all the different concepts of that thing which individual people have, and to *the extent to which these concepts coincide*." (the italics are mine)

Without wishing to enter here the unresolved philosophical debate of how 'meaning' and 'concept' are related and whether one is subsumed in some way under the other, in the context of this argument, it seems necessary to point to the meaning attributed to a word by most people. Unless questioned rather

closely, people generally expect that the same word, although used with different attributes from time to time, indicates some commonality.

One would normally expect that all items of furniture referred to as a 'chair', be they armchairs, soft chairs, high chairs, metal chairs, wicker basket chairs, rocking chairs or deckchairs, allow one to sit in or on them. If a 'chair' turns out to be entirely unsuitable for its commonly assumed primary purpose, one would feel somehow deceived. In other words, there is at least one aspect in which all possible 'conceptions' of what a chair might be, what it might look like, or how or from what material it might be constructed, coincide, and that is that one may use it as a seat.

I would maintain that whatever people may expect from a nurse, if they are subjected to the experience of being nursed, whether by a general, psychiatric, district or theatre nurse, they are likely to expect that there is an element in her activities which coincides *to some extent* with elements in all other activities called 'nursing'. That nurses themselves expect a commonality between all things called 'nursing' is evidenced in many ways, however much nurses may argue about their various differences.

For example, the disappointment voiced by psychiatric nurses about the apparent unsuitability of most forms of nursing care planning for their particular field of nursing (Harris 1970, Palisin 1971, Aidroos 1976, Schröck 1980) indicates not only that

psychiatric nursing is seen by them to be different in some way, but also that they expect something that refers to 'nursing' to be applicable and useful in the psychiatric field *to some extent*. If this were not so, the feeling of disappointment could not arise.

The disenchantment with certain of the endeavours and results of nursing research also points to the fact that nurses expect a degree of relevance and applicability from investigations that are defined as 'nursing' research. I have found no indication that this disappointment where it was articulated, was in any way modified by considerations of differing conceptions of nursing. (Silva 1977)

It seems to me that the process of creating a concept of nursing (or more likely, many concepts of nursing) from an as yet to be established body of knowledge (or various forms of knowledge) that is inherent in Rickelman's explanation of the relationship between the forms and the contents of nursing knowledge, is not going to lead to the desired results. It may indeed be one of the causes for some of the perplexities of nurses, two of which I have just described.

The form that nursing knowledge should take, that is, the entity referred to as a body of knowledge, a range of knowledge or a conceptually whole knowledge, cannot be created by apparently random excursions into all possible areas of investigation in the hope that somehow these initially completely unrelated searches will produce components of knowledge that can be fitted together

into a meaningful whole. It seems that this approach is more likely to perpetuate what has in fact been the traditional method of defining the expected extent of nurses' knowledge. Without reference to how nurses saw their functions and tasks, the content of what they were taught and expected to know was based on developments in other disciplines, mainly in the biological and medical sciences. The contents of knowledge were then produced by natural scientists and medical researchers, while now some of these contents may be produced by nurse scientists and researchers. No articulate conceptualization of the nurse's functions emerged from the contributions of components of knowledge which were produced by natural scientists and medical researchers. I do not expect a meaningful contribution to the conceptualization of nursing to emerge from the components of knowledge which are now produced by nurse scientists and researchers without an *initial* reference to current concepts of nursing practice.

I have already said that some of the knowledge produced by nurse researchers is considered by other nurses to be irrelevant to nursing practice.

An overview of 175 nursing research projects conducted over 13 years in the United States of America clearly illustrates the also fragmented nature of nurses' search for knowledge. (Abdellah 1970) It appears as if the phenomena which nurses chose to investigate were selected rather arbitrarily and randomly. How nurse researchers choose their areas of work, what influences this choice, and how it could be directed to become more profitable

than it often appears to be are questions which need to be answered by empirical methods of investigation. There must be facts attending these issues which can be established by asking first-order questions. These, however, are not the province of my argument.

For the purpose of my question, of which I have not lost sight - namely by what criteria we could recognize the new or particular kind of knowledge for which nurses are searching - the above mentioned survey provides some evidence that the relationship between the forms and contents of this new knowledge is by no means established.

I do not wish to deny that there is value in knowing some things, even if these items of knowledge appear to be unrelated; but the point is that if this new knowledge is to be characterized by the endeavour to identify, define, conceptualize, circumscribe and structure it in such a way that it resembles an organised whole of some kind, then there is little evidence that this is being achieved by random enquiries, and there is even less evidence that a "conceptualization of nursing within these forms", as postulated by Rickelman , is at all feasable.

For example, Abdellah points out that in the surveyed projects clinical research efforts were focused primarily upon problems dealing with the child. Five such studies were conducted, and reported between 1962 and 1968. Researchers studied the dependent behaviour of children to assess the effects of nurses' nurturance or its denial, discovered play interview techniques to be useful

in assessing preschool children's reactions to hospitalization, described the nature of crying as a physiological state of the newborn infant, set up an experimental study to determine the nursing care of premature infants by their mothers at home, and compared the effects of needle and jet spray injections of medications in preschool and school children.

No matter how one would attempt to organize and structure these items of knowledge, it does seem very unlikely that any kind of conceptualization of (paediatric) nursing would emerge from such an attempt.

That this is not a state of affairs peculiar to paediatric nursing, which I simply chose as a handy example here, is shown by the many who echo Fuller's conclusion (1978);

> "A review of research in nursing reveals a fragmented array of studies defying the identification of unity and order in their results as well as in their conceptualizations."

In an unpublished and undated discussion paper, Cahoon set out a tentative typology of and for nursing research because "The existing body of knowledge of nursing is an unwieldy meld of knowledge ... (and) is particularly fragmented ...".

It appears to me that she expresses a common contradiction here. If, as she says and I have tried to show, nursing knowledge is fragmented, then by my understanding of what 'a body of knowledge' might be, this entity must be non-existent in nursing. If it exists in some form, then it should not be fragmented.

The search for nursing knowledge independent of any explicit conceptualization of nursing produces another, distorting effect.

The most frequently mentioned "goal of nursing is improvement of practice through the development of a body of science in nursing and the application of this science in practice." (Editorial 1970)

Abdellah (1970) confirms this clearly when she considers the "major gaps" in nurses' search for knowledge:

> "Clinical research of problems related to nursing is considered by most nursing leaders to have high priority."

This priority, however, is not reflected in the knowledge that is actually produced by nurse researchers.

Of the 175 research projects in Abdellah's overview, only twelve are categorized as "clinical research of problems related to nursing practice", and even if one adds six studies which are concerned with "model and theory development" related to nursing practice, the total of eighteen practice orientated projects does not reflect adequately and proportionally the most frequently voiced reason for the acquisition of more (or new) knowledge.

This distortion between what nurses say that they most urgently need to know and what those who search for nursing knowledge actually go out to find, is not only characteristic of American nursing research. It has its parallels in British nursing research. (Clark & Hockey 1979)

In looking back over my examination of the first of the two statements which I had hoped would illuminate the relationship between the forms and contents of this new nursing knowledge, I find that the process postulated by Rickelman -

1. would not remedy the prevailing random search for nursing knowledge
2. would not necessarily produce more deliberate, fitting and balanced nursing knowledge
3. would not facilitate the structuring and systematizing of parts of nursing knowledge into a meaningful entity
4. *would not produce the forms of nursing knowledge*
5. would not identify commonalities in nursing
6. would not serve to conceptualize nursing
7. *would not produce the contents of nursing knowledge.*

It therefore appears untenable in its postulates.

My first model of the construction of forms, if it represents Rickelman's approach, would therefore not be a suitable one to apply to the acquisition of nursing knowledge and its structuring.

As I cannot logically conceive of any other alternative process of structuring nursing knowledge than that represented in my second model of the construction of forms, I must turn my attention to the examination of Henderson's statement which I believe

indicates a process that resembles this alternative. Henderson's starting point for the development of nursing knowledge is an analysis of the practice of nursing. To her,

> "It is self-evident that an occupation, and especially a profession, whose services affect human life must define its function."

She also acknowledges that "this is still an unfinished business". (Henderson 1966) But if nursing knowledge is to be developed from an analysis of the practice of nursing, then some picture must exist in the mind of the analyst which is a conceptualization of nursing. It will have been created by the personal knowledge and out of the experience of nursing which the analyst possesses, and it will be informed, and probably will have gained its general features from what the analyst knows about other nurses' knowledge and experience. It is a picture of nursing generally as she sees it. Although she may never have thought much about it, or articulated it in any way, the picture of the world of nursing that she possesses provides the foundation for her contribution to the development of nursing knowledge. I maintain that no nurse functions without some, however dimly perceived *Weltbild* of nursing. It may be rather diffuse, much like a photograph that is out of focus, and therefore the person holding such an image may find it difficult to identify and describe its pertinent and most salient features.

I am reminded of a simile used by Stevens (1979) in trying to explain the nature of a theory.

> "A theory is like a map of a territory as opposed to an aerial photograph. The map does not give the full terrain (i.e. the full picture); instead, it picks out those parts that are important for its given purpose. If its purpose is travel, the map is likely to highlight roads; if its purpose is to describe the physical characteristics of the earth, it shows mountains, plains and rivers. But no map (or theory) reflects all that is contained within the phenomenon."

I feel that the picture of nursing - the way a nurse sees her world as a nurse - resembles the aerial photograph. It may contain so many complex features, and even strange, disturbing and unidentifiable ones, that at any one time the holder of this picture can only consciously perceive and deal with selected features of this world of nursing. But whether it is a reasonably sharp, well developed picture or rather a fuzzy one taken from a great height, the nurse needs, and develops in the course of her experience of the practice of nursing, a '*Weltbild*'. This mental image of nursing will greatly determine her function as a nurse, and must serve her in order to make decisions and choices. Without some choices and decisions, there is no practice of nursing as, indeed, without them there would be no recognizable human activity of any kind. It is said often that many practising nurses would not be able to answer the question what nursing is, that is, they would not be able to define it or to articulate their personal view of it. I mentioned a particular instance of this apparent inability to present an articulate view of the nature of nursing earlier in this argument. But this cannot logically be construed as evidence that either nurses practice without a general concept of nursing or that there is a danger, if they were to articulate their views, that nursing as we know it

would mysteriously vanish. Neither can one deduce from the fact that nurses generally are unable or unwilling to offer an articulate view of nursing, that such a view is not needed. (Storlie 1970)

I still find Stevens' simile useful in pursuing my argument, and I will therefore return to it.

Let us assume that I wanted to construct a map for the particular purpose of travelling by car in an hitherto unmapped area of the world.

If I followed Rickelman's postulates, I would send off as many travellers as I could find, asking them to bring back any information about unknown roads that can be used by cars. Since I have given them no indication of the area in which I wish to travel, they would most likely go off into many different parts of the world and return with information about the roads which they discovered. But this would not help me to construct even a rough map of the particular area in which I had intended to travel, since the probably correct, but unrelated bits of information from any of the travellers who by chance had reached the area, would not fit together to produce a usable map. It might also turn out that by chance, no one had actually travelled in that part of the world.

I could, of course, tell them the approximate location of the area to ensure that they all travelled somewhere in or at least near it. But if they knew no more than its likely location, a great deal of time would be needed to eliminate obviously unsuitable

terrain for my intended travels. The whole area may not even be thoroughly explored, if all my assistants were to move about at random. It is likely that quite a few of them will explore the same part of the area, because it is nearest to where they started, or because it has a track which appears promising. Their view of what the whole area might look like might be obscured by a mountain range. They may never discover that a very passable road had been built on the other side of the mountains. Again, my map would be very incomplete and very likely it would be misleading, if I accepted my assistants' assurance that the obstacle to any further travel consisted of a large mountain range covering the rest of the area.

But if I could obtain an aerial photograph, or better still, a series of such photographs taken from different angles and at different times, we could decide before setting out on our search for passable roads, where in the area they are most likely to be found. We might be able to identify those features which would make it more or less likely that roads existed in their vicinity. We might expect that the part of the area which is covered by a great expanse of water would offer little chance of transversing it by car. We might be able to identify the precise location of high mountains, and notice in doing so, that right in their centre there appear to be some large man-made buildings. There should be, or should have been once, a road leading to this spot. I would expect that a systematic search concentrating on the most likely parts of the area would produce more valid information to help me with the construction of a reasonably useful map. It is of course

possible that in actually exploring a particular part of the area, it turns out that the feature which in the aerial photograph appeared to be a fairly flat stretch of land, is a rather swampy moor. I would then have to amend my general picture of the whole area accordingly. But in any case, the possession of the aerial photograph in the first place will have saved a great deal of unnecessary and fruitless travelling and will have helped me to utilize my assistants to the greatest possible effect. And I am certain that I could not have obtained the equivalent to an aerial photograph by any other means than by taking it.

All similes have their limits and inherent simplifications. But the way in which nurses search for *nursing* knowledge does seem to resemble more often than not the less productive ways illustrated by my example.

If nursing knowledge is to serve a purpose, and I have allied myself with those who assume that it should serve the practice of nursing, then a general concept of what this practice is all about and how it is viewed by those who engage in it, is a necessary prerequisite for the search for knowledge.

I think that Crawford *et al* (1979) in analyzing theory development in nursing are making the same point in saying

> "... we suggest that the thinking surrounding theory development in nursing and directed towards the building of nursing knowledge has evolved to a point exemplified by the following statements. 1) All knowledge utilized by the profession of nursing is not nursing knowledge; only those theories and knowledge which have been derived from nursing's perspective comprise nursing knowledge.

> 2) Nursing knowledge will be developed from nursing's unique perspective by asking questions and viewing phenomena unlike other discipline. (sic) 3) The knowledge base of nursing will be developed from basic, applied, and prescriptive research in nursing. *The urgent task for nursing is to continue to clarify and make more explicit the unique perspective and focus of nursing.*"
> (the italics are mine)

I have tried to argue that a narrowly defined 'scientific' search for the form, structure and organisation of this particular kind of knowledge which is variously referred to as a body, a range, a systematic structure, an identifiable area, or a conceptually whole knowledge is not possible.

I have also tried to show that the contents of this knowledge must be secondary to its forms.

I have accepted Henderson's postulates in preference to Rickelman's, since they appear to offer the only logical process by which this new nursing knowledge can be developed, and I have therefore dismissed my first model representing the structuring of forms as unsuitable for nursing. I have adopted the assumption that a given specific form (of knowledge) will allow certain available components (items of knowledge) to be fitted into it while others will remain excluded.

In what way has my argument so far answered the questions which I raised in response to the fact that nurses are saying that they need a new knowledge? Why do nurses need a new knowledge and by what criteria might this new knowledge be identified?

Having accepted at least one of the offered reasons why nursing might benefit from a search for knowledge, namely the potential improvement of patient care, I tried to show that the terms which are used to describe this knowledge imply certain criteria which refer to different aspects of it.

Before one can examine the expectations, uses and relationships of this knowledge, I argued that one needs to discover the relationship of its forms, contents and methods of enquiry. I have tried to show that the contents of nursing knowledge must be secondary to its forms, since the latter cannot be established or created from fragmented items of knowledge which have been acquired without any reference to a clearly articulated concept of nursing.

The criteria which might identify this new knowledge must therefore include first and foremost a clearly defined concept of nursing or, as some writers have put it, an explicit perspective of and focus on nursing. It is only with reference to a conceptualization of nursing that *nursing* questions may be asked which may lead to items or components of *nursing* knowledge. And it is only possible to structure, organize and unify these items of knowledge into a recognizable entity by their reference to a fundamental conception of nursing which led to relevant nursing questions being asked in the first palce. It is the demand that the *new* kind of nursing knowledge be *formed*, *structured* and *organized* in a particular way which constitutes an important criterion by which it might be recognized.

I would therefore conclude that the *new* knowledge for which nurses are searching is identifiable by

1. its explicit *nursing* perspective

2. its structure and organisation based on a clearly articulated concept of *nursing*

3. its demonstrable potential to improve patient care through *nursing* action.

I would like to forestall a particular criticism of these criteria. 'An explicit nursing perspective' and 'a clearly articulated concept of nursing' are two phrases which refer to what I have earlier called the nurse's '*Weltbild*'. I think that I have been careful in avoiding the impression that there should or could be 'the' nursing perspective or conception, or *one* picture of nursing which informs all nurse researchers and nurse scientists. But I still hold it to be essential to attempt an analysis of the extent to which various concepts of nursing coincide.

Unless some commonalities can be demonstrated, there would be no further point to this argument. If there is such a thing as nursing knowledge, it must be identifiable

> "by a unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry." (Donaldson & Crowley 1978)

I do not advocate an interminable quest for *the* definition of the nature of nursing (apart from the fact that formulating definitions

is not quite the same as clarifying a concept), but I do agree with Donaldson and Crowley that

> "it might behoove us ... to seek relationships and commonalities in the ideas of writers whose work has influenced (and continues to influence) tacit knowledge of the scope of the field."

I will defer the problem of how nurses might set about creating and articulating a nursing perspective of the kind advocated by Donaldson and Crowley, because I have so far omitted to consider the third element which I thought it necessary to relate to the forms and contents of nursing knowledge, namely the methods of enquiry by which such knowledge may be acquired.

> "In the 1960's and early 1970's differences of opinion could be identified in the literature concerning how to develop knowledge in nursing. With a focus on scientific research methodology as the means to development of knowledge, Simon argues for an inductive approach and Putnam argued for a rational-deductive approach." (Crawford et al 1979)

Induction versus deduction, however, is only part of a generally rather confused argument about the appropriateness of various methods of investigation which are aimed at the development of nursing knowledge.

McKay (1977) suggests that we do not at present have any recognized methods and that we do not know what criteria might make researchers' findings acceptable in nursing. This view is somewhat contradicted by the assertion that it is precisely the acceptance of certain research methods, to the exclusion of possibly others, which constitutes a major obstacle to the development

of nursing knowledge. (Stevens 1977)

Others criticize the borrowing of research methods from other disciplines, and consider a rigorous adherence to such borrowed methods to be a cause of retardation and of trivialization of nursing knowledge. (Dickhoff, James & Semradek 1975)

> "Where a researcher approaches a discipline with tools (methods) already in hand, the tendency is to search for a subject matter that fits those tools ... Here, then, is a situation where trivial answers will be found because trivial questions are asked." (Stevens 1979)

The 'accepted' research methods which seem to find nowadays more critics than friends tend to be those of the oldest or 'hardest' sciences, that is, the empirical sciences. Social science research, where it most tries to approximate natural science investigations, draws the same kind of criticism of methodological bias toward the classic experimental design which frequently is considered unsuitable for and inappropriate to nursing research. To Stevens (1979) it appears

> "evident that nursing with its complexity of subject matter, must develop unique methods of inquiry, if it is to acquire meaningful knowledge."

Earlier writers on the subject appeared more confident that nursing knowledge may be developed with well-known and well-tried methods of investigation.

Not only was it accepted that "The very roots of nursing practice stem from the biological and physical as well as the social sciences" (Abdellah & Levine 1965), it was also assumed that the nurse researcher "must learn to use the tools of research

peculiar to the (physical and/or social) science ...". (Dorigo 1968)

As doctors have based their investigations into medical practices "on the older disciplines of the physical, biological and behavioural sciences", so nurses were expected to evolve nursing knowledge in a similar way "as an applied scientific discipline". (Scott Wright 1973c)

The preparation and training of nurse researchers who were "to develop techniques for measuring the quality of nursing care" included an introductory course which dealt with research methods in the clinical and social sciences, and with the study of the statistical method. (McFarlane 1970)

There appeared to be some hesitation in identifying clearly the 'sciences' which should serve as either a model for nurses' investigations, or from which material contributions could be expected. They were usually denoted by such collective designations as 'the biological, physical and behavioural sciences', which creates the unwarranted impression that these categories contain a generally accepted and discrete number of disciplines, and that all of these might yield similarly beneficial results for nursing. Neither were all the writers on the subject unanimous about which of these broad categories they considered to be fundamental sources of either knowledge applicable to nursing, or of the methods of investigation to be mastered and emulated.

Dorigo (1968) leaves out the biological sciences, or perhaps includes them in the category of the natural sciences. This confirms that the content of these categories is not generally agreed.

Neither is it clear whether the 'clinical sciences' mentioned by McFarlane (1970) consist of the natural and biological sciences, since the social sciences retain their separate identity in her exposition, or whether the clinical sciences are distinguished from the social sciences by their methods, or by some other criterion such as their contribution to the traditional content of medical knowledge.

How far the term 'scientific' may be narrowed even in comparison to the writers who include 'natural, biological and behavioural sciences' in their discussion when advocating a 'scientific approach' to nursing is shown by Wilson (1964) who sees "many facets to nursing ... one of these facets is scientific knowledge ...". She explains that she will deal "mainly with the scientific aspects of nursing" but that this knowledge cannot exist alone and must be complemented by other kinds of nursing knowledge which are equally important, such as "the understanding of the patient as a person". This seems to suggest that 'scientific' here is reserved for the study of the natural sciences (implying, I think, that the behavioural sciences are not 'scientific'). Nonetheless, here is one writer who indicates the content of the category 'science' as perceived by her.

> "The science subjects which are referred to here are anatomy, physiology, pharmacology, bacteriology, chemistry and physics as they apply to nursing."

In spite of very general categories on one hand and the narrowing of the concept of 'science' on the other, there appeared to have existed a certainty among the earlier writers that the

'scientific method' is not only acceptable in the search for nursing knowledge, but also that it provides the only possible approach in nursing enquiries.

This certainty that the methods of investigation which have been fruitful in the natural and social sciences would also, if appropriately applied to nursing, lead to the desired knowledge in nursing, has in the short span of a decade given way to doubt and uncertainty. How this uncertainty is expressed by nurse researchers without, however, causing them to change their fundamental assumptions about 'the method' appropriate to nursing research, may become apparent in a closer examination of Cahoon's position.

In setting out a tentative typology of and for clinical nursing research, the writer claims that

> "There is no single scientific method, there are a number of methods that are collectively referred to as the scientific approach
> ...
> Nursing research ... is guided by the scientific approach."

This statement is part of a series of explanations and definitions offered by Cahoon which suggest to me the following line of reasoning.

A body of cumulative 'scientific' knowledge drawn from the physical, biological and behavioural sciences becomes, by a process of synthetization, unique nursing knowledge. This nursing knowledge is synonymous with nursing science.

Nursing research leads to nursing knowledge, hence to nursing science.

Nursing research uses the 'scientific approach' to produce this knowledge/science.

There are a number of unspecified methods which constitute the 'scientific approach' but since nursing knowledge/science is a mix of the biological, physical and behavioural sciences, it must utilize the methods of investigation that characterize these sciences, that is, the methods of the empirical sciences.

Nursing research method therefore is synonymous with empirical science method.

It seems that the declaration quoted above was somewhat superfluous. There may be 'a number of methods that are collectively referred to as the scientific approach', but clearly by this reasoning, only one of them is relevant in the search for nursing knowledge.

What makes it impossible to come to any other conclusion is the *starting point* of the argument which resembles Rickelman's approach to the identification of the forms and content of nursing knowledge.

In trying to relate the method of enquiry to the forms and contents of nursing knowledge, Cahoon is representative of the earlier writers on the subject by starting with various undefined and largely unstructured components (that is, the physical,

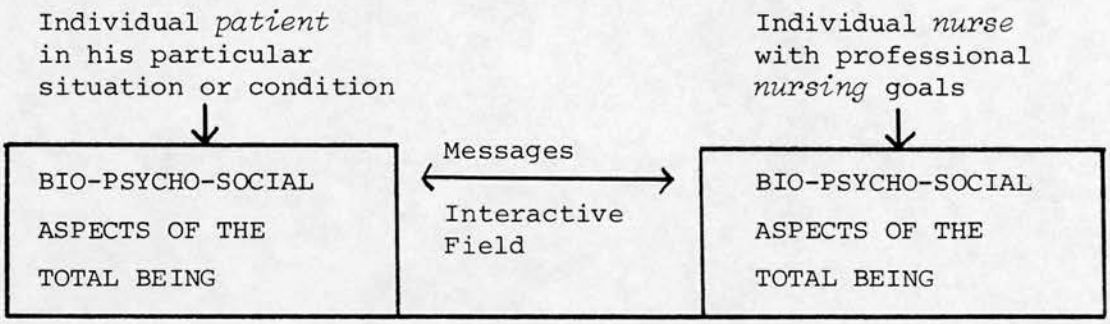
biological and behavioural sciences). Both Rickelman and Cahoon suggest that a process of synthetization converts knowledge from other disciplines into unique nursing knowledge. There is no indication, however, by what criteria items of knowledge from other disciplines may be selected in order to be synthesized into a new form of knowledge. That some selection must take place is likely, since it would not appear feasable or necessary to reconstruct *all* that is known in the natural, biological and social sciences into some hyperconstruction for the benefit of nursing. Since one must also assume that no nurse researcher is conversant with *all* the knowledge that may potentially contribute to this synthesis, whatever may be selected is likely to be determined by the individual researcher's grasp and knowledge of another discipline. As the reference to nursing follows and not precedes this selection in both Rickelman's and Cahoon's argument, what is unique about the possible outcome of this process is not 'a synthesis unique to nursing', but a synthesis unique to each individual nurse researcher. This is not to say that such individual constructions of knowledge are valueless or useless, only that they cannot and do not provide "a systematic structure of knowledge differentiated from the functions and structure of other health disciplines." (Rickelman 1971)

The communication model, for example, created by Rickelman which combines aspects of communication and linguistic theory, and which is conceptualized by her as "bio-psycho-social linguistics" is a conceptual exercise which could be applied to all other health care endeavours besides nursing. Simply using

this model in nursing does not make it uniquely part of nursing knowledge.

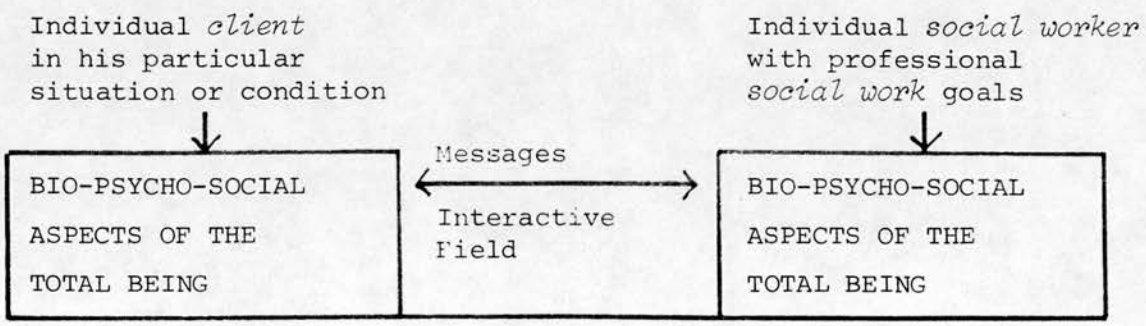
An abbreviated but in no way distorted version of the model should illustrate this point quite clearly.

Rickelman's bio-psycho-social linguistics model applied to nursing



There is no problem in substituting any other identity for 'patient' and 'nurse'. For example, a substitution of 'client' for 'patient' and of 'social worker' for 'nurse' is entirely feasable.

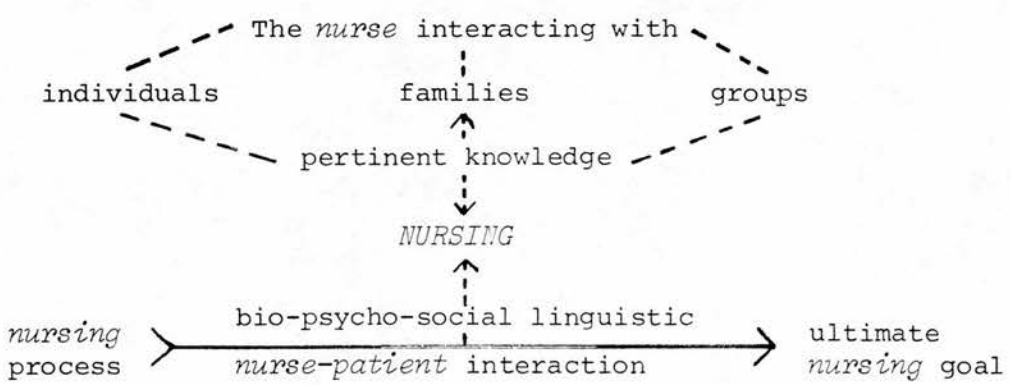
Rickelman's bio-psycho-social linguistics model applied to social work



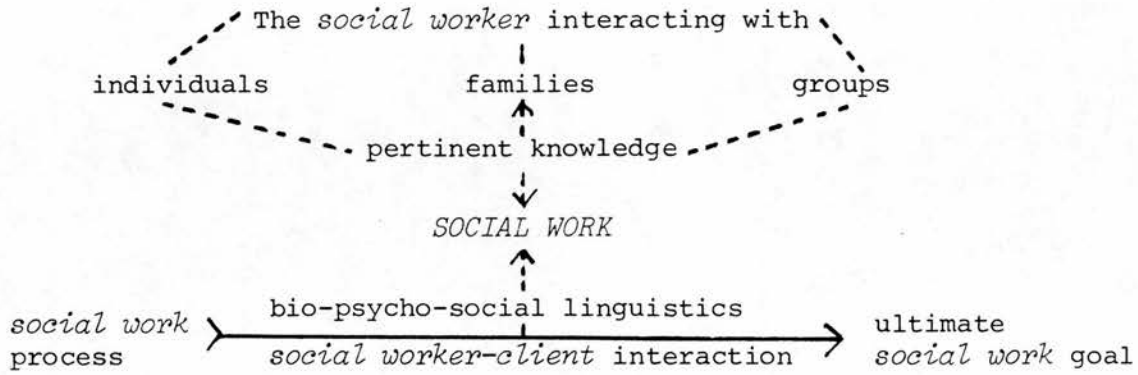
The model retains its validity to whichiver practice it may be applied as long as that practice is a social process which involves interaction between people. I would also argue that no synthesis is involved in the presentation of this model. It remains, and quite properly so, a theoretical conception of a particular aspect of a social science discipline.

The attempt to construe a model of the "components of professional nursing" derived from the aspects of communication and linguistic theory contained in the "bio-psycho-social linguistic nurse-patient interaction" model can only lead to a construct which again is equally applicable to other professional endeavours, and is in no way unique to nursing. Substitution does not invalidate this derived model either, as the following illustrations will show.

Rickelman's model of the components of professional nursing



Rickelman's model of the components of professional nursing applied to social work



Some important conclusions appear to be justified from the foregoing argument.

Scientific knowledge drawn from the physical, biological and behavioural sciences does not become *nursing* knowledge simply by its application in nursing. It remains quite clearly what it is, that is, physical, biological and behavioural science knowledge. This is not to say that knowledge drawn from other disciplines may not be applicable to nursing, in the same way in which it may also be applicable to social work or medicine.

But this knowledge is not synonymous with *nursing* knowledge/ science since it not particularly identifiable by

1. its explicit *nursing* perspective

2. its structure and organisation based on a clearly articulated concept of *nursing*

3. its demonstrable potential to improve patient care through *nursing* action.

Even if a process of synthesis could be identified which I failed to do in the offered example, it would not lead to something that is uniquely nursing, but it would quite properly enrich or complement the knowledge in the disciplines from which the re-formed items were taken in the first place.

The fact that a particular method of investigation would verify or falsify conceptual or theoretical constructs in a particular discipline, cannot lead to the conclusion arrived at by both Rickelman and Cahoon, that the same method must be appropriate in nursing investigations.

The offering of conceptualizations derived from other disciplines, however useful they are in their original contexts, must lead to "a fragmented array of ... conceptualizations" (Fuller 1978) which defy any attempt at ordering them into a unified and intelligible form or structure that is 'unique to nursing', for the simple reason that they do not belong to nursing but to a multitude of other disciplines.

Nursing knowledge/science is not simply a mix of the biological, physical and social sciences, and need not utilize necessarily or exclusively the methods of investigation which are characteristic of these sciences.

In recent years, some writers have expressed the conviction that "Nursing has both scientific aspects and aspects akin to the arts." (Donaldson & Crowley 1978)

While some of these give examples of disciplines or branches of knowledge which are usually described as belonging to the 'arts' rather than to the 'sciences', such as history, politics, economics, education and "even cybernetics and theology" (Zbilut 1977), others have included the "liberal arts" as a more general category along with the 'physical, biological and behavioural sciences'. (Scott Wright 1973b)

But apart from the fact that there is hardly a subject which has not been thought to be useful and even necessary to nursing, there emerges a difference in the way in which the concept of 'art' is utilized in relation to nursing.

There are those who argue that "knowledge from political science, history, philosophy, and other disciplines is very important". (Donaldson & Crowley 1978) They clearly see the 'arts' as another source of relevant knowledge in the same way in which the sciences are thought to possess knowledge that nurses should utilize for their own purposes and should, as argued by some writers, integrate or synthesize within a specific nursing perspective.

There are others who see the 'art' in the execution of nursing skills. As McFarlane explains, "the art of nursing lies in skilled performance ...". (1976) She considers it to

be axiomatic "that the art of nursing consists of actions of a nursing nature which are informed by knowledge or science." (1978)

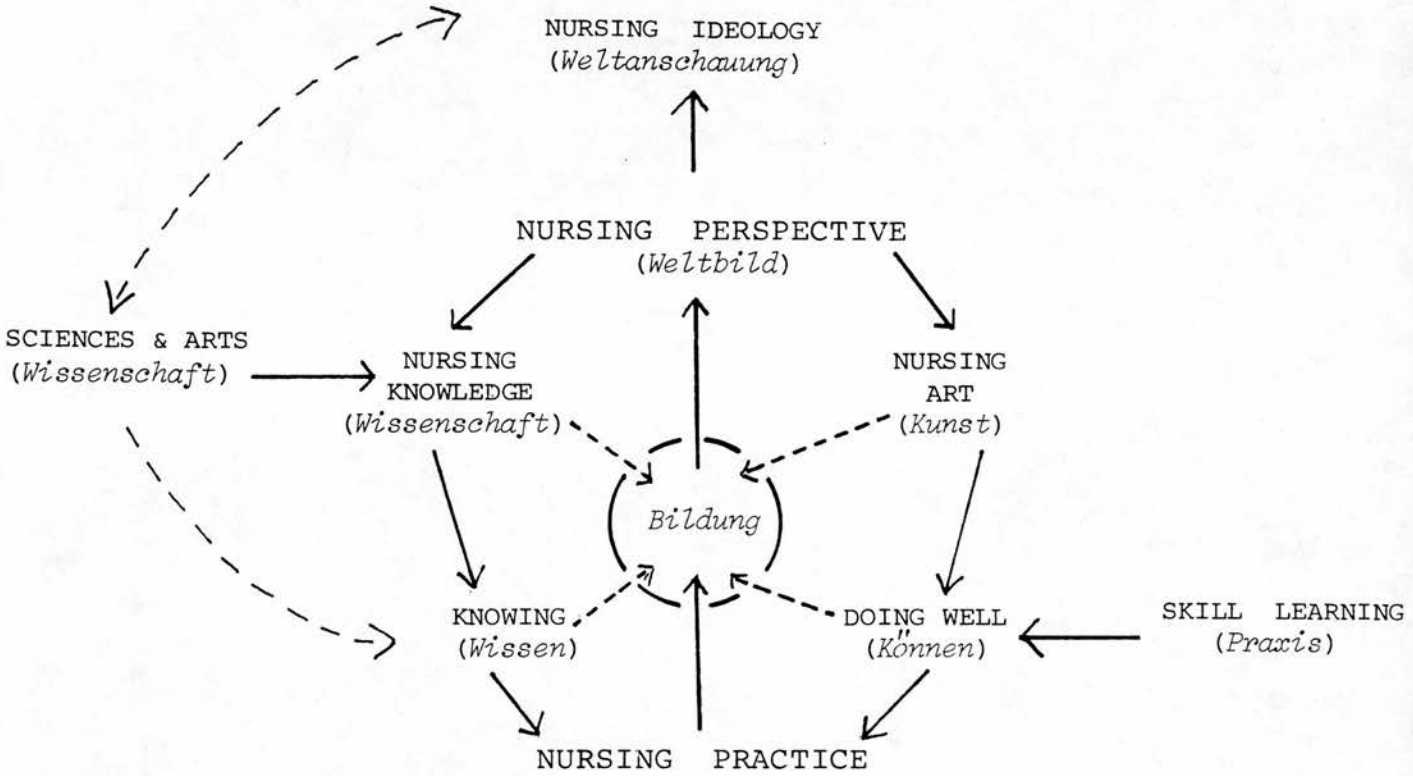
If one argues, as McFarlane does, that "the science (of nursing) rests upon the art (of nursing)" and then equates (nursing) knowledge with (nursing) science, the implications appear to be different to those who see in the 'arts' a different source of knowledge for nursing that should be utilized as well as knowledge derived from the sciences.

But these two positions are not irreconcileable. It seems to me that the apparent confusion is caused by the limitations of a language which does not provide one word that unequivocally embraces all sources of methodically acquired knowledge with their appropriate and accepted canons of proof or justification ('*Wissenschaft*'), and reserves a distinct expression ('*Kunst*') for a skilled performance which goes beyond technical competence by its "perfection of execution" and by being a "process of creating something beautiful." (McFarlane 1976)[4]

There is good reason to believe that nursing as an art and as a science can be informed by both the arts and the sciences, and that such knowledge as may be derived from either of these may be utilized, conceptualized, synthesized, or handled within a 'nursing perspective', and may inform nursing practice.

The following model which is meant to show that the two positions derived from different interpretations of 'arts' and 'art', are not irreconcileable, may also illustrate what I take to be

McFarlane's argument. In addition, it may assist in placing some of the German words which, I feel, distinguish more readily between various important points of this argument.



It is important to the whole of my argument to see the relationship between nursing practice and a relevant nursing perspective as a dynamic process. All models are artefacts and tend to convey rather mechanistic conceptions. I do not, at this point, wish to rehearse all the parts of my argument so far which might support this representation, since this would take me too far away from the methods of investigation under discussion at the moment. But I must acknowledge my inability to find a precise and succinct English term for the central

component of my model (that is, *Bildung*), which denotes the process by which a nurse might acquire and develop a nursing perspective.

However, the central question under discussion at this point in my argument is whether nursing needs to utilize necessarily or exclusively the methods of investigation which characterize the biological, physical and social sciences.

Donaldson and Crowley (1978) developed a distinction which might be useful in clarifying the problems involved in deciding in what ways nursing knowledge should or might be developed. They define two dimensions of what might be called the discipline of nursing. (The word 'discipline' indicates in their argument "true distinctions between bodies of knowledge" and a particular "realm of learning".) The "substantive structure" consisting of the conceptualizations that fit the discipline's perspective, is developed, so they and others argue, by expositions of practice models and theories in order to build a "focused and cohesive conceptual system" in nursing. (Johnson 1974)

The "syntactical structure' is composed of the research methodologies and criteria which are used to distinguish acceptable from unacceptable findings.

In their paper, Donaldson and Crowley are careful "not to equate the discipline of nursing with the science of nursing", because "only part of nursing employs scientific method (sic)."

They clearly see the scientific method (in its usually accepted sense of denoting inquiries conducted on the patterns of natural science research) as only one way of contributing to the syntactical structure of the discipline of nursing.

Although they focus the discussion on the substantive structure, they seem to imply that inductive and deductive methods are only some of the ways of developing nursing knowledge and that other methods are also necessary. In creating the substantive structure of the discipline, they say,

> "philosophical, historical, and similar types of enquiry within the discipline of nursing is (sic) crucial not only in terms of providing the knowledge base for professional preparation but also for the development of the discipline."

Another writer supports this view by pointing out that

> "Nursing faculties rarely have among their members scholars who are concerned with establishing the history of nursing science and with identifying the philosophies or conceptualizations of nursing that have influenced the structure of that knowledge at various times in nursing's history." (Schlotfeldt 1977)

Leaving aside for a moment the explicit but dubious equation of "philosophies" with "conceptualizations", Schlotfeldt's point of view is taken up by other writers in a similar form.

McKay (1977) suggests that not all nursing knowledge is 'scientific' in nature and that the use of 'non-scientific methods' such as of historical and philosophical enquiries is essential. Frequently, similar statements can be found in articles and books which are almost entirely devoted to the explanation of, and to comments on, more narrowly defined

scientific research methodologies, almost as if it had become obligatory to acknowledge this sentiment, but not necessary to follow it with any more detailed examination of what these 'non-scientific' methods entail and in what particular ways, in fact, they may differ from what constitutes the greater substance of the article or book. (Clark & Hockey 1979; Stevens 1979)

This tendency of pointing to the 'essential' contribution that philosophical enquiries are expected to make to nursing, but then to leave it as an intriguing but superficial remark, or to select rather arbitrarily, as is illustrated by the quotation from Schlotfeldt, one aspect of a philosophical endeavour and equate it with the whole, is one of the main reasons for my putting forward the arguments in this thesis.

It would not be true to say that no writer has attempted to define or explain more clearly what the nature of such 'non-scientific' enquiries might be.

As early as 1956, Hillway endeavoured to explain how nursing knowledge may be acquired and he concluded that it will come about

> "through one or more processes that may be arranged in the following progression:
>
> 1. Intuition (a glimpse of 'truth', unconscious)
> 2. Authority, tradition, custom
> 3. Chance (accidental personal experience)
> 4. Trial and error (deliberate personal experience)
> 5. Generalization from experience
> 6. Logic, deduction, syllogistic reasoning, or a formal argument with a major and a minor premise and a conclusion

7. Inductive reasoning - a conclusion arrived at by related particulars, especially numerous observations
8. Research, scientific inquiry, or a structured, systematic investigation to answer a question, throw light on a theory, or solve a problem."

This suggested progression in the search for nursing knowledge has been almost completely neglected by subsequent writers on the subject, and especially by those evincing an interest in the 'non-scientific' methods of enquiry. It certainly contains aspects that should be examined from a philosophical point of view in order to judge their validity in this context.

Henderson (1966) rather disarmingly admits that she finds it difficult to present an argument for nursing research, as she is unable to see any argument against it. As nursing research at that time almost exclusively relied on and utilized 'scientific' approaches, Henderson certainly was exceptional in holding a wider view, and was perhaps not unjustified in being tolerant rather than unreservedly enthusiastic about the beginnings of scientific enquiries in nursing.

By referring to Hillway's explanation and by concluding that "it seems obvious that all these processes are useful, even necessary", and that

> "Perhaps the most civilized man is the one who recognizes all of them and chooses in each case what he believes to be the appropriate basis for his acts",

Henderson was expressing a view of a process by which an individual develops a picture of the world in its widest sense, and acquires '*Bildung*' rather than, or as well as '*Wissen*'.

It is pertinent to note that it took some years before a few researchers returned to Henderson's position, that the basis for the development of nursing knowledge must be the conceptualization of nursing through an analysis of the nurse's clinical experience, and at the same time, began to question the methods of investigation which were current at that time. This confirms to me that there is a close relationship between the forms of knowledge and the methods of enquiry which are employed to discover their appropriate contents, or between Donaldson and Crowley's substantive and syntactical structures which define the dimensions of the discipline of nursing.

Two writers who have made fairly explicit in what ways, in their view, a philosophical approach might differ from a more narrowly scientific one, are Dickhoff and James. Their explanation of philosophy as an approach is, I think, most clearly demonstrated in a paper which was basically concerned with the examination of beliefs and values in nursing. (1970)

It is worth devoting some thoughts to their argument, not only because it is probably the most detailed one in this context, but also because their departure point for seeking knowledge lies in nursing practice. Although both writers are philosophers, and not nurses, they were certainly seminal in reorientating nursing research to nursing practice, and influential in stimulating nurse theorists to develop a 'practice theory' in nursing.

Where science based nursing attempts to create certainty by the quantification and by the ordering of facts, the philosophical

approach encourages what these two writers call "systematic ambiguity". Dickhoff and James see the philosopher's contribution not in forcing choices in order to resolve any uncertainties, but in maintaining a sense of ambiguity to allow for the greatest possible exploration of the issue at hand before, as it were, the case is closed. They point out that

> "Philosophers tend to emphasize differences even if they irritate or offend a little rather than ... to smooth over or avoid delicate points."

In contrast to the scientist who is preoccupied with the detail and the "enumeration of detail", the philosopher's tendency is to be global and overarching, and to seek completeness and thoroughness by emphasis on structure. Simplicity that is achieved by selection or elimination would be anathema to the philosopher even at the risk of being accused of "philosophic obfuscation".

Dickhoff and James further argue that the familiar tends to be hard to "see really"; therefore what they call "deliberate disorientation" should be a tool of analysis, before people build on things which they feel they know without really knowing them. They continue,

> "We consider philosophy a discipline with no beforehand restrictions on method or subject matter and a discipline that uses thought as a critical tool ... in genuine philosophy thought is conceived as functional in action, is based on or not ignorant of the real, and, moreover, is committed to shaping the real through action guided by this very thought."

The "philosophic characteristics" which in these writers' opinion would profit nursing are:

1. a habitually large surveying focus, as opposed to concentration on isolated, specific detail; and the capacity to do without the gratification of achieving immediate and concrete results from present activities

2. the related habit of seeing the general tendency of a situation rather than its immediate detail and, hence, the custom of seeking what is right or what is possible in situations rather than the tendency to see what is wrong or impossible, and

3. the capacity for frontal attack as well as for compromise.

Dickhoff and James suggest

> "that nurses cultivate as values certain practices or habits of philosophers:
>
> 1. Capacity to entertain systematic ambiguities, without losing capacity to make an appropriate resolution of ambiguity where practice of nursing or teaching demands it.
> 2. Cultivation of a healthy disrespect for the merely venerable, without losing respect for history and experience as a source of enlightenment.
> 3. Boldness to suggest and work with new terms or new structures when the old and familiar is deemed inadequate, but without losing sight that both for institutions and for effective change new concepts alone are not enough.
> 4. Confidence to render overt and explicit and to exploit constructively errors, difficulties, frustrations, and embarrassments, without resorting to mere confessions of guilt or termination in gossip.
> 5. Patience and scope to seek simplicity through integration rather than through mere selection or enumeration, but maintaining the executive skill for seeing through detail and being able to be decisive in action even when conceptual tentativeness cannot be resolved in time for action.

6. Using examples and anecdotes as mere heuristics and not as a substitute for theory or generality, but without using generality as an excuse for losing the link to action or the key to communication.
7. Courage to seek purposeful disorientation as a step toward a richer reorientation, without getting hooked on puzzlement as a perpetual state of mind."

Dickhoff and James' position needs further examination, and inspite of their disclaimer that "not all philosophers are ... real philosophers", it must be compared with what other philosophers declare the methods of philosophy to be. But there is little doubt that the "sense of indignation" about their "cynicism" experienced, for example by Wiedenbach (1970), demonstrates the effectiveness of their argument in stimulating a debate about the methods of enquiry current at that time.

I would date the slowly increasing criticisms of the kind of knowledge that nurse researchers produced, and which had hitherto been accepted with a degree of self-congratulation by the profession, though it was (and still is) rarely utilized in informing or in changing practice, from the publication of Dickhoff and James' work at the end of the 1960's.

But just as the methodological progression in the search for nursing knowledge suggested by Hillway and taken up by Henderson was not subjected to further examination and was not utilized for the development of the 'non-scientific methods of enquiry' in nursing, so Dickhoff and James' perhaps more provocative exposition remained largely unexamined.

Instead, a methodological analysis by Stevens in 1971 concerns itself with the 'logistic, dialectical, operational and problematic method', which again has a distinct 'non-scientific' flavour.

The assumption that here is another attempt to define more specifically some aspects of the 'philosophical method' of enquiry is partly confirmed by the writer's declaration that

> "The purpose of this investigation was to clarify philosophic concepts underlying ... common curriculum structures ...".

This examination, of what are essentially methods of reasoning, was later extended by Stevens (1979) to identify how nurse theorists utilize 'different thought patterns' in the construction of their various theoretical perspectives. Based on a now unobtainable paper by McKeon, in which these methods were described as not only having a long tradition but also as still being operative in contemporary philosophy, they are explained by Stevens in a way which differs to some extent from the more usual explanations of the meaning of the first two terms as they are commonly employed in philosophical discourse.

Where the term 'dialectic' no longer retains its original (Socratic) meaning of referring to the conversational method of argument involving question and answer, it either becomes largely synonymous with 'logic' as it did for the Stoics and the Middle Ages, and to some extent to Kantian philosophy as a means of exposing fallacious reasoning, or it expresses the reconciliation of opposites as in the Hegelian progression from thesis and anti-thesis to synthesis. Plato often used the word 'dialectic' for

philosophical method in general and "came to apply it to whatever method of enquiry he favoured at the time." (Lacey 1976)

Stevens' notion in explaining the dialectic method, namely that the whole "governs the relationships and provides coherence to the parts of that whole" appears to be derived from Hegel's version of the coherence theory of truth, but I am not at all certain that a consistent Hegelian viewpoint is expressed in her claim that the "dialectic method works by *taking as its perspective a whole* that it organizes." (the italics are mine) Nor do I think that Hegel's progression to a higher level by way of thesis, antithesis and synthesis allows "contradictions to be seen as *compatible components* in a larger unity." (the italics are mine)

Although I could not claim to grasp Hegel's notoriously obscure writings, from what I can gather, he maintains that contradictions need to be reconciled and that falsity needs to be removed by '*Aufhebung*' between thesis and antithesis. That is, contradictions are seen as irrational self-cancellations which are removed before the whole process is repeated at a higher level. The whole point seems to be that the whole as Hegel sees it, does *not* contain any contradictions, so there cannot be any "compatible contradictions" in a larger unity as Stevens claims.

Similarly, the impression created by the phrase "taking as its perspective a whole" sounds rather more like Plato than Hegel. Hegel's whole is, as I understand it, the *result* of his particular method of arriving at the truth which *is* the whole. The whole of which he speaks is a developing whole and it develops through

the medium of contradiction. His dialectic is generally regarded as a process of argument that *proceeds* to the whole starting with an initial proposition.(Flew 1979)

Stevens' explanation, however, sounds to me as if the whole were the organising principle from the start. Her comment that the nurse theorist who is "a good example of a dialectic thinker" is "little understood by most readers of theory" and

> "may be the recipient of esteem from those nurses who mistakenly assume that any theory must have merit if they cannot understand it",

may be less than charitable, but it is also indicative of the dubious value of emulating one of the most obscure philosophers.

I find less difficulty with her explanations of the logistic method with its emphasis on the construction of relationships, although I had considered it to be more truly characterized by its analyses of scientific theories into formalized statements of symbolic logic or of mathematics.

The important point here is, however, that whichever way defined, 'dialectic' and 'logicism' are recognizably part of certain philosophical enterprises.

The 'problematical' and 'operational' methods which she includes, are not so easily located in the general context of philosophical methodology. Saying that the problematical method is designed to recognize and define unique problems with their attendant factors which in turn must harbour the solution to the problem, does not really identify the philosophical source of

this particular approach, and the statement that "In a sense the agent *is* the (operational) method" makes me think more of behaviourist or interactional methods than of philosophy.

I have chosen to include Stevens' account although I am not at all sure what exactly my difficulties are, particularly in respect of finding the philosophical sources for the last two 'methods'. What I am certain about is the clear intention of the writer to detail some aspects of what McKeon calls "the semantic schemes that have been used in philosophy."

I seem to have reached a similar state of bewilderment as I experienced when I tried earlier on to identify the forms and contents of the knowledge that nurses say they need. In defining and delineating philosophical methods of enquiry in nursing, each writer seems to pursue a different kind of explanation.

Where one attempts to show a progression through different methods of enquiry, of which one or two appear to have philosophical aspects, the other seems to consider the states of mind that unspecified philosophical methods might bring about such as ambiguity, disrespect, and disorientation. McKeon's 'semantic schemes' are interpreted by Stevens as ways of reasoning, as different thought patterns and as different ways in which "meaningful terms" are put together. "The method of thought" is being described as dialectical, logistic, operational and problematic. But are all "methods of thought" philosophical in nature? This seems a large claim to make which I feel cannot be settled without a further and much wider examination of how philosophers describe their ways of

working as being distinctly different from those of others in search of knowledge.

Zbilut (1977) does not help to reconcile these rather disparate attempts of defining or delineating the input of 'non-scientific methods' into nursing knowledge by presenting "four broadly defined methodological levels of thought" which he terms the empiriological-existential, empirical-metaphenomenal, philosophical-metaphenomenal, and philosophical-transcendental. Except that it represents a progression to different levels of enquiry similar to Hillway's and Henderson's notion of a methodological progression in the search for nursing knowledge, it shares little else with their explanations. If I understand Zbilut rightly, he sees a progression from empirical descriptive research to the formulation of hypothesis, theories and laws, which in turn are taken and applied to the "two basic conditions of human existence, i.e. space and time", and which are finally incorporated into a wide view of man giving a "unique formality to human existence".

What we have here is not so much an emphasis on method (as in Hillway's and Henderson's progression) but different levels of thought about the human condition.[5]

By examining "the four main branches of philosophy - logic, epistemology, metaphysics, and ethics", Silva (1977) claims that all scientific nursing research "is derived from or leads to philosophy". She explains that

> "through logic, researchers are able to establish the validity of various thoughts and the correctness of their reasoning."

Epistemology, she says, establishes the 'truth condition', the 'belief condition' and the 'evidence condition' of the research. To metaphysics belongs the concept of causality which is central to scientific research, and finally, "the study of ethics comes to grips with moral principles and values." Apart from selecting various aspects of what one might call the subject matter of philosophy as being useful in relation to nursing research, Silva also comments on the legitimacy of philosophical introspection and intuition as "methods of scientific enquiry".

Griffin (1980) sees the "distinctive contribution" that philosophy can make "for the development of nursing theory, research and education" in its

> "particular methods to help us think with persistence, intensity and generality about what we are doing."

The particular interest of the philosopher in value questions, including those of a social and political nature, should help nurses to accomplish ethical analyses which appear to be needed in many areas of nursing.

A few more explanations of the kind which I have briefly described and commented upon, can be found in the literature, but not only are the attempts to explain what might constitute relevant 'philosophical knowledge' in or for nursing rather infrequent, they also appear to evidence the same deficiency as the more frequent attempts to define nursing knowledge per se. They are fragmented,

and it seems impossible to me to create from them a coherent picture of what the contributions of 'non-scientific methods of enquiry' which some authors consider to be necessary in the development of nursing knowledge, might be.

I believe that nurses have set out on a search for knowledge or on a journey of discovery for a variety of reasons which may well be related to each other in some ways but which tend to follow somewhat different paths. Although there is an implied concensus that this 'new' nursing knowledge should improve patient care, there is little concensus about its form(s), contents or the methods by which it might be obtained. Inspite of this apparent uncertainty, the methods of enquiry which are predominantly utilized by nurses are based largely on a fairly narrow interpretation of the 'scientific method' of enquiry. This almost exclusive claim of the 'scientific method' being *the* appropriate method in pursuing nursing knowledge may have been necessary in gaining 'academic respectability' with its attendant access to the necessary resources for study and research. But 'academically respectable' knowledge seems to have fallen short of being useful in improving patient care. The challengers who indicate the necessity for 'non-scientific methods of enquiry' do so largely in responding to what they see as the inadequacies of the 'scientific' method. It seems, however, that they - just as their 'scientific' colleagues have done before them - start with very different viewpoints from which they attempt to produce the contents of this 'non-scientific' knowledge, and to identify the methods by which it might be obtained, without examining first the form or forms that it should take.

I would also argue that a somewhat narrow knowledge of another discipline, or a preferred aspect of it, might lead to a subjective selection and application which will have a distorting rather than a unifying result.

I would not claim that anyone will ever have a complete grasp of a particular discipline, but I would assert that a philosopher should have a reasonably general idea of the current parameters of philosophy, in the same way in which a nurse theorist should have a reasonably coherent picture of the current parameters of nursing.

In other words, we need to know more about the body and range of knowledge, its systematic structure, its identifiable area and its conceptual wholeness, that is, we need to know its form or forms before we can judge the appropriateness of any of its contents or methods in relation to other forms of knowledge.

We need to know more about philosophy and more about nursing in a general sense, before we can decide which specific contents and methods may be of use in the search for nursing knowledge.

I have argued that nursing knowledge must be developed from analyses of the practice of nursing based on a general conceptualization of nursing.

I shall argue that the identification of philosophical 'knowledge' and 'methods' which may be useful to nursing must be based on the practice of philosophers within a general conceptualization of philosophy.

NOTES TO PART ONE

1 I had originally said, "a fact as such is *meaningless*". I am still not convinced that this is not exactly what I meant to say, although I perceived the difficulty which one of my supervisors experienced in accepting this statement. A philosopher's enquiries into 'meaning' as part of the philosophy of language, explore various aspects of our understanding of words and sentences. One aspect of the notion of 'meaning' is its connection with other psychological conditions, such as wanting or intending, and with human conventions and rules. Many writers have analyzed the meaning of a sentence in terms of it being "normally used by those intending to bring about a certain result in an audience." (Flew 1979) Without such an intention and without an appropriate response by a listener (on the assumption that language serves the purpose of communication), an utterance of whatever kind remains 'meaningless'. Once again, two German words denote much more clearly the difference which I am trying to elucidate. '*Sinn*' and '*Bedeutung*' would both be translated as 'meaning', or possibly as 'sense' and 'meaning', but they are by no means synonymous. A word or sentence may have a '*Sinn*', but no '*Bedeutung*' for any listener. The factual assertion by a chemist that iron oxidises in the presence of oxygen has a meaning ('*Sinn*'), but may be meaningless ('*bedeutungslos*') to a listener who has no knowledge of chemical processes. What I am trying to say here has a meaning, but it may still be meaningless to a non-German speaker or to a person with no appropriate 'psychological condition', such as wanting to understand the 'meaning' ('*Bedeutung*') of my utterances. One can even go further and claim that a 'meaningless' ('*sinnlose*') utterance like 'boo-pa, boo-da' has a 'meaning' ('*Bedeutung*') in a speech therapy session where it may serve a particular purpose in learning to articulate certain sounds. "Word and meaning are not the same. A word is simply a sound or a written symbol for something meaningless (*bedeutungslos*!). ... The meaning (*Bedeutung*) which we attribute to a word, may change without the word being changed. ... The utterance as such does not 'possess' meaning (*Bedeutung*), only the 'understanding subject' (*das verstehende Geschöpf*) can attribute meaning (*Bedeutung*) to an utterance." (my translation from Apel 1953)

2 The following observation by Fodor and Katz (1971) illustrates the importance of the context in which an utterance is made, or in which it is put by the listener: "The same utterance will be associated with a given speech act under certain environmental conditions but not under others. For example, if I utter 'A travelling salesman was looking for a place to spend the night', then, depending upon the environmental condition, I may be making an assertion, starting a joke, referring to a joke, giving an example, providing an explanation, quoting, informing, talking to myself, damaging my reputation, and so forth. But

the environmental conditions which determine which, if any, of these acts I am performing can clearly not be discovered by merely examining the utterance."

3 A given form or set may be repeated an infinite number of times or may have an infinite number of components or members, as, for example, is indicated by the mathematical symbol of x^n. But this does not make x itself infinite. The notion of infinity as it occurs in philosophical arguments from classical times onwards, is vague and loosely taken as "that which has no beginning or end" or "that which has no boundary, internal or external". (Flew 1979) It appears paradoxical to talk of forms as structures, whether of a symbolic, conceptual or material kind, which all serve to organise, define, permit inclusion or exclusion of certain members, components or characteristics, and then to consider them to be infinite in themselves.

4 In a talk given to the members of the Scottish National Nursing and Midwifery Consultative Committee, Altschul (1977) offered a range of criteria by which the performance of nursing actions might be evaluated as an art. These included their aesthetically pleasing nature, the elements of creativity and inspiration, the apparent ease in the performance of a difficult task according to rules geared to a certain standard, and the sense of accomplishment, success and pleasure which may be invoked in the performer or in the onlooker. In the effort to demonstrate the scientific foundations of nursing, says Altschul, and possibly as a result of an increasing awareness of cost-effectiveness, "We seem to have downgraded the acquisition of skills in favour of knowledge and comprehension, so that nurses' actions are sometimes no longer performed in an aesthetically satisfactory way." It is indeed pertinent to ask, as Altschul does, whether we should not try to determine whether an aesthetically pleasing nursing performance has any therapeutic effects.

5 It has been suggested to me that Zbilut's and possibly Stevens' attempts at explaining the nature of philosophical enquiries need not be taken very seriously. Whether this suggestion was based on the judgement that these writers are not very good philosophers (which they probably are not) or on some other criterion, I do not know. But I would maintain that it is important to examine such attempts at explaining non-empirical methods of enquiry in nursing with care and concern. Apart from the fact that nurses have to learn (as I am doing) to handle this kind of explanation in the same way in which they had to learn empirical methods of investigation, *these are the only kinds of explanations which we have at present.*

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PART TWO

THE MARKET PLACE

The claim of nurse writers to a philosophy of nursing; ideology misrepresented as philosophy; misunderstood ethics; the rights of patients as a moral proposition; the scarcity of social and political analyses; nursing as an applied science in need of conceptualizations; toward a theory of nursing?

THE MARKET PLACE

Explanations which are aimed at defining and delineating philosophical methods of enquiry in nursing are not only diverse and usually fairly brief, they are also offered very infrequently.

But since I have chosen to develop my argument from the demonstrable fact that nurses are engaged in a search for knowledge of a particular kind, and that this search, fragmented as it may still be, includes occasional attempts to explain what might constitute relevant 'philosophical knowledge' in or for nursing, I cannot proceed without examining some rather more frequently found examples of the use of 'philosophy' in the nursing literature.

I am going to make a deliberate distinction between the attempted explanations of philosophy in or for nursing as provided by Hillway, Henderson, Dickhoff and James and by others previously mentioned, and those uses of 'philosophy' which I am about to examine.

I consider the difference between these two groups of writers to be so important that I avoided discussing them together in the same part of the thesis.

Much more frequent than the kind of explanations offered by Dickhoff and James, or Stevens is the use of the word 'philosophy' as denoting "an integrated viewpoint toward certain beliefs and practices." (Gardener 1973) The custom to talk about 'a philosophy' or about 'the philosophy' of an individual, of a group of people,

of the profession, or of an institution in the context of established beliefs and values which may be prevalent in nursing, appears to have originated in the North American nursing literature.

Chapman (1978) comments that

> "The use of the word philosophy is perhaps a dangerous one as British nurses frequently laugh at their American colleagues because of their preoccupation with the 'philosophy of nursing'."

I am not sure that this use is dangerous because it can be ridiculed, but I think that it may be dangerously misleading for other reasons.

In some of the papers by American nurse theorists, the origin of the use of philosophy as synonymous with values and beliefs is attributed to educational theory. (Walker 1971, Ogundeyin 1976)

Walker bases her conclusion that the "discourse of nursology" (that is, talking about the study of nursing) is accomplished by three modes of inquiry, on an analysis of educational theory by Maccia (1968). According to this analysis, the scientific mode of inquiry provides a description and explanation of nursing phenomena as they occur, the praxiological mode describes and explains what constitutes effective nursing practice while

> "In the philosophic mode a description and explanation is provided of what constitutes worthy means and ends for a given practical endeavour."

In other words, the philosophical method of enquiry is here clearly defined and delineated by the question 'What is worthwhile nursing?'.

It goes far beyond this argument to examine the nature of educational theory, or to deal fully with Ogundeyin's claim that "A philosophy of education is a statement of values regarding what should be taught in the educational institution." (1976)

Contemporary British texts in the philosophy of education would suggest that this view is not accepted (Archambault 1972, Lloyd 1976, Schofield 1972) and that the approaches taken by British philosophers of education are not only concerned with very different issues, but also very specifically declare the prescription of practical actions based on certain value systems to be an illegitimate aim for the philosopher. One quote shall stand for many which express the position of British philosophers of education in this respect:

> "Philosophers are no longer to be regarded as the guide of humanity, in education or anything else. Moreover, if someone were to argue that the philosopher as a human being may have some desire to do at least what he can to leave the world a little better than he finds it, a common contemporary philosopher's reply would be that there is not the slightest reason to suppose that his philosophical reflections - say upon some aspects of the problem of values - would render him in any way more competent to pronounce or advise on practical affairs." (Reid 1972)

But "to pronounce and advise on practical affairs" is precisely what these "statements of philosophy", whether they are made in the context of nursing education or practice, are meant to do.

"The course philosophy" as a statement of what should be done, or of what should be achieved in a given educational endeavour has become a standard pronouncement of nurse teachers. (Newell 1978)

"The statement of philosophy contains the broad goals of the educational program and how these goals are to be attained", declare Gordon and Anello (1974) in an explanation of a systematic curriculum revision. The use of the word philosophy to indicate what ideally should be *done* is even more clearly narrowed down to a list of prescribed actions when it is used in the context of nursing practice and of instructions for the preparation of nursing students for this practice.

"The Philosophy of 'Briggs'" (Collins 1977) may be an extreme example of a selection of verbatim recommendations for action taken from the Report of the Committee on Nursing 1972, and published under the above title with the, in this context irrelevant, explanation of philosophy as "The pursuit of wisdom, or of the knowledge of things and their causes - *the study of ultimate realities and general principles*." (the italics are mine)

Some writers indicate that the system of beliefs and values denoted by the word philosophy is, or may be, an outcome of philosophical reflection which is indeed concerned with a systematic and searching analysis of

> "a system of thought - political, religious, ethical, educational, (and which is) concerned with reality, origins, the nature of man, the purpose and the meaning of existence, the nature and sources of knowledge, the science of exact thought, and the nature and realm of values." (Wagner 1969)

I think that this implies the development of a '*Weltanschauung*' based on a '*Weltbild*'.

I have argued earlier that the acquisition of knowledge (*Wissen*) may make a person knowledgeable but that being knowledgeable is not enough by itself. Knowledge of facts, their relationships, their causality and their effects can remain disconnected and disjointed. To arrive at a coherent picture of the world (*Weltbild*), a person needs to conceptualize and to synthesize this empirical knowledge into a meaningful whole. It is in the process of creating a '*Weltbild*' that philosophical methods of enquiry may prove to be useful, if - as various writers insist - philosophy is fundamentally concerned with the study of ultimate realities and general principles.

I would therefore agree that "Philosophy helps a person to develop a coherent world view, one which makes sense of every-day experience." (Lanara 1976)

I do not agree that the system of beliefs and values which a person may hold and on which he or she may act, is either necessarily or even potentially a function of philosophical thought. A '*Weltanschauung*' may well be influenced by the ideas which have been formed in the process of philosophizing (Treece 1974), but their adoption as articles of belief which may eventually form a personal or professional 'ideology' are a function of social life.

An ideology (or a *Weltanschauung*) expresses the interests of particular groups of people in particular circumstances, and will be used to justify such actions as are compatible with the interests of the group in question. (Larrain 1979, Williams 1976)

That this is precisely the function of the so-called 'philosophy' of nursing is clearly expressed by Gordon and Anello (1974):

> "... after the faculty have discussed and clarified their beliefs, a committee can then draw up a rough set of philosophical statements emanating from the discussion."

But this statement of the group's 'philosophy' must be

> "coherent and consistent with the overall purpose of the institution. ... Faculty must therefore examine and clarify the institutional goals *before* formalizing a philosophy of nursing education." (the italics are mine)

It is certain that ideological structures serve to increase loyalty to the group, and that they are fundamentally necessary in "the selection of modes, means and ends of action." (Godfrey 1971) But in serving these purposes, ideologies are expressions of a commitment which accepts at least for the time being certain 'truths' while

> "... the essence of philosophy is not the possession of the truth but the search for truth ... It is a disinterested pursuit, to which questions of utility ... have no relevance." (Jaspers 1951)

Whatever the Concise Oxford Dictionary may say, "the rules for the conduct of life" are not drawn up by philosophers nor do they constitute 'a philosophy'.

My particular concern that the use of philosophy as synonymous with ideology should be exposed as being dangerously misleading is that *it confuses questions with answers, uncertainty with certainty, scepticism with conviction, examination with result, and personal doubt with group concensus.*

An acceptance of 'philosophy' in the form of recommendations, however valuable and proper they may be, spells the end of philosophy as a valid method of enquiry, and incidentally of course, the premature end of my argument. I am conscious of the possible problems of defining the expressions of fundamental sets of shared beliefs and values as 'ideology', since this term does not have an undisputed and generally accepted meaning either. However, in the absence of a more exact translation of '*Weltanschauung*' which has the advantage of not being used in the pejorative sense of 'ideology' as being an "abstract, impractical or fanatical theory" (Williams 1976), I cannot offer a less controversial choice.

Feibleman (1958), as will be seen later, talks about 'official philosophies' as compared with philosophy proper. I do not think that this is a clear enough distinction between two conceptual endeavours which aim at completely *opposing* states of mind.

Dickhoff and James (1970) in criticizing the use of the word philosophy in a similar way, although less fully than I have done, suggest that "What nurses tend to call 'philosophy of nursing' we as philosophers would tend to call a 'religion of nursing'."

Not only do I fear that the substitution of 'religion' for 'philosophy' might cause even greater troubles than offering 'ideology' for 'philosophy' where the latter is used inappropriately; I also think that it is further misleading.

Dickhoff and James emphasize that the integrated and consistent personal attitude towards life and reality which underlies a nurse's shared and central purposes is "fixed" and held "either dogmatically ... or (is) at least not open to systematic scrutiny and possible change." They also maintain that

> "these beliefs and values are held by an individual as a person rather than as a nurse or as a professional, and held in common, if at all, only by happy chance."

Undoubtedly, there are such beliefs and values but those which I found presented in the nursing literature and with which I took issue were not necessarily of this kind. Gordon and Anello, for example, make it quite clear that a reexamination of the "philosophy" is an essential task that has to be accomplished from time to time and they emphasize that 'the philosophy' must be flexible enough to accommodate changes. Chapman's paper constitutes a reappraisal of current beliefs and values in nursing, and Lanara traces the development of the current 'philosophy of nursing' from classical Greece to the pronouncements of the International Council of Nurses and of the World Health Organisation.

I would argue further that any such ideological revision necessitates the use of philosophical methods of enquiry; the very reason that they should be clearly distinguished from the matter to which they may be applied.

Another example of such an examination of the ideological basis of nursing is provided by Gamer (1979) who claims rightly, I think, that there is a

> "growing divergence between the ideological aspirations of the official spokesmen and of the practical interests of the working nurse ...".

This is not a question, as Dickhoff and James suggest, of beliefs and values held by individuals as people rather than as nurses, but of the ideology of professionalism

> "which served to unite nurses in the attainment of licensure and higher educational standards (but which) can no longer hold together a group which is stratified by education, achievement, personal goals, and perceptions of the nursing role."

Furthermore, not only are the so-called 'philosophies' of nursing part of the wider ideologies of the institutions in which they find their realization (for example, the hospital, the college) but as Wagner (1969) says distinctly, they include "the concepts that a civilized society looks upon as being right, reasonable and reachable."

The obvious problem here is of course that contemporary industrial society does not present a homogenous structure of beliefs and values but "consists of differentiated groups or subcultures each having the propensity to develop patterns of values in its members." (Godfrey 1971)

So far from being "fixed", ideological structures in nursing are under frequent and conflicting pressures. To what an extent and in what way nursing ideology responds to these pressures must depend on the ability of nurses to handle confidently the tools of conceptual analysis and ideological revision.

Where this ability and confidence are lacking, it is likely that nurses will be reluctant to occupy themselves with the confusion and entanglements that seem to threaten their professional lives. They may console themselves with the thought that these discords are merely transient and that fundamentally everything is alright. It may well be that here Dickhoff and James's 'dogmatically held sets of beliefs and values' do become apparent. Nursing ideology may turn at this point into myths which rest on "numerous clichés, platitudes and strange contradictions which point ... directly to a set of unsubstantiated beliefs ...". (Reinkemeyer 1969) Whether we may call these myths the "religion of nursing", I dare not say, but they have lost the power of what I would call an ideology, namely to justify such actions as are in the interest of those who subscribe to it.

However, whether we are dealing with reasonably coherent ideologies as perhaps expressed by the articulate spokesmen and -women of the profession, or with the clichés and platitudes which may serve others as a less coherent and less articulate rationale for their actions, the real

> "function of philosphy lies in its *criticism of what is prevalent* ... The chief aim of such criticism is to prevent mankind from losing itself in those ideas and activities which the existing organisation of society instills into its members. ...
>
> (Philosophy) means the lack of faith in the prevailing popular thought. ...
>
> By (its) criticism, we mean that intellectual, and eventually practical effort which is not satisfied to accept the prevailing ideas, actions, and social conditions unthinkingly and from mere habit; effort which aims to coordinate the individual sides of social life with each other and with the general ideas and aims of the epoch, to deduce them

> genetically, to distinguish the appearance from the essence, to examine the foundations of things, in short, really *to know* them." (Horkheimer 1972 - the italics are mine)

If I have come full circle in this argument which started with the observation that philosophy might contribute relevant *knowledge* to nursing, then I have returned to the central question which I have set out to examine.

The claims to a 'philosophy of nursing', which are based on a misleading confusion caused by ideological statements being dressed up as 'philosophy', lead to a dead end as far as any philosophical enquiry is concerned. This is succinctly expressed by Feibleman (1958) who observes

> "For institutions often adopt official philosophies, and official philosophy can be the death of philosophy. To adopt a philosophy officially means to have discovered the final truth; and it ends inquiry into the nature of truth by claiming the possession of it ..."

Such false claims to a 'philosophy of nursing' must be clearly distinguished from the attempts to *explain philosophical enquiries* in or for nursing even though these explanations are so far not altogether satisfactory. But what is on offer as 'a philosophy of nursing' is simply not worth buying. The idea that "Sensible people ... have a *philosophy* (while) silly people rely on *ideology*" (Williams 1976) is really both naive and offensive.

Furthermore, the use of the word philosophy *is* dangerous inspite of the spreading transatlantic custom to talk in this way about nursing ideologies or even nursing myths. Philosophical issues in nursing are not exemplified by a collection of assumptions and beliefs. This does not do justice to the contribution which

philosophical methods of investigation can make to the study of nursing. It not only appears to confine philosophy to a very narrow function, it also attributes to it a purpose which it does not have.

It behoves us to look further for the meaning of philosophical enquiries in nursing.

When surveying books and articles concerned with 'ethics' in nursing, applied to nursing or for nurses, one may hope to find at least here some indications of the appropriateness and usefulness of philosophical enquiries. Unfortunately, it seems to me that again nurses have adopted a terminology (possibly following a medical tradition in referring to certain professional issues as 'ethical' or 'ethics') which promises much, but generally does less than justice to that branch of philosophy known as ethics or moral philosophy.

It is true that moral philosophers differ in the interpretation of their task. Nowell-Smith (1954) rightly points out that traditionally moral philosophy has been regarded as a practical endeavour in providing knowledge for moral action, that is for doing what is right.

But even classical philosophers[1] do not undertake to give detailed practical advice on how people should behave in certain situations. However,

"they all agreed that the goal of moral philosophy is practical knowledge, not that we should know what goodness is but that we should become good."

But if philosophical treatises from Plato and Aristotle to Hobbes and Spinoza contain injunctions to do something rather than another, to adopt this or that course of action, or to subscribe to this or that moral code, these injunctions are usually *implicit* in the nature of their discourse.

Firstly, classical moral philosophers examined a rather general and fundamental question: what is the good life for man and what is happiness? They saw their task in describing the good life in principle or in general outlines, and in showing how it could be achieved. Secondly, they held the view that people would naturally act in such a way as to try and achieve the good life, if they knew what it was. In other words, by offering *knowledge* about good and bad, right and wrong, by means of *a rational discourse*, this knowledge *had to be practical*, since all rational men, who could follow the argument, would inevitably act in such a way as to lead a good life.

In order to find answers to these very general questions about the kind of life that people might lead in striving for individual happiness and collective security, the classical moral philosopher had to range over a wide field of human concerns. Since men must live with one another, life in society and politics had to be discussed. Indeed, ethics and politics were, for these philosophers, one subject. They saw their function in elucidating

principles which might eventually affect individual conduct. Some later philosophers called this endeavour which aimed at

> "systematising the different ends of human action and the different sets of rules for practice, or ideals of what ought to be",

practical philosophy and distinguished it from other philosophical concerns referred to as theoretical philosophy. (Sidgwick 1902)

The latter, by contrast, would be concerned with all those endeavours which might lead to an understanding of the world in its widest sense but for its own sake, without either implicitly or explicitly relating this understanding to any consequent actions.

This distinction between practical and theoretical philosophy in relation to ethics was, and occasionally still is, made in comparing the contributions of, say, Plato with those of Broad and Ross. (Nowell-Smith 1954) Where Plato tried to provide an understanding of the good life with the implicit assumption that people would act on this understanding (that is, practical philosophy), Broad and Ross are predominantly concerned with the study and analysis of moral terms, moral judgement and the nature of moral discourse generally (that is, theoretical philosophy).

At first sight, this appears to be a useful distinction to make. Sidgwick (1902) suggests, for example, that "such professions as Medicine" are in need of practical philosophy. Nurses too have acknowledged that they need to

> "justify one form of behaviour over another, to determine the right-making characteristics of action, for purposes of carrying out duties and obligations." (Davis & Aroskar 1978)

What is now on occasion called normative or applied ethics can be seen, for the purpose of my argument, as being synonymous with practical philosophy.

What has been called theoretical philosophy is termed by some nurse writers on the subject 'meta-ethics', which, however, is then quite narrowly defined as that aspect of ethics which "delineates the extent to which moral judgements are reasonable or otherwise justifiable." But even this aspect of moral discourse does not appear to be of importance to nurses. "Health professionals are primarily concerned with ... normative ethics", claim Davis and Aroskar (1978).

The almost inevitable conclusion to which this distinction between the rather narrowly conceived tasks of theoretical and practical philosophy leads, is to assume that practical philosophy in the form of normative or applied ethics only is of importance to nurses. The outcome of this now already limited conception of ethics is often what is called 'ethics' in nursing. It consists of generalized prescriptions for professional conduct which tend to resemble ideological statements rather than that they constitute *an examination of values which may justify these statements*, and *an analysis of how moral judgements based on these values* are made.

Heading these pronouncements on 'ethics' in nursing is the "Code for Nurses" (1973) of the International Council of Nurses. It is meant to be "a guide for action based on values and needs of society." (ICN 1977) An accompanying text presents "ethical considerations in nursing practice" by providing fifty examples of the kind of nursing situations which contain the seeds of a moral dilemma. (Tate 1977) There is, however, no exposition of tenable moral theories or principles which could form a basis for a critical analysis of the presented situations. The questions put to the reader which centre around the issue of what to do, are not informed by any kind of practical or theoretical philosophy in the original sense of these terms. What has got lost, quite possibly due to the distinction made by philosophers between practical and theoretical philosophy which I do not think to be as valid as it might at first appear,[2] is the endeavour

> "to give a true account of what it is to make a moral judgement, to decide, deliberate and choose, as well as to answer moral questions in a more direct way." (Nowell-Smith 1954)

All moral philosophers, including the classical writers, have always been theoreticians. That is, they have argued the *reasons*, their underlying assumptions and theories, for their description of the good life and how it may be achieved.

It seems to me that *arguing the underlying assumptions is the proper function of professional ethics.*

There is, as far as I could ascertain, only one British author (not a nurse) who makes this point clearly and consistently when

dealing with moral dilemmas in medicine and nursing. Campbell (1975) explains the concern of ethics as being directed towards the "understanding of the nature of moral judgments". In this endeavour, ethics attempt to "provide a rational framework for understanding the complexities of moral judgments" and to clarify the meaning of moral terms like good and bad, right and wrong. As an "abstract, analytical, uncommitted approach" ethics, Campbell claims, are 'characterized by the spirit of radical enquiry". The moral philosopher does not attempt to 'solve' moral dilemmas or

> "to provide any form of specific *moral* guidance such as rules for right behaviour ... His function is not one of moral guidance but one of objective analysis."

It seems to me that nurses tend to narrow down philosophical enterprises to the point of distortion and falsification in a surprisingly consistent way. When one compares Campbell's explanations of the nature of ethical enquiries in relation to moral dilemmas in health care with the explanations offered earlier of how philosophical enquiries might assist a person in the acquisition of a consistent and coherent view of the world, and if one then examines what nurses actually do and offer as 'philosophy' or 'ethics', one reaches very similar conclusions. In each case, what nurses offer should more accurately be described as ideological statements or statements of belief.

More serious than a possible confusion of terminology is again the confusion between questions and answers, between uncertainty and certainty, between scepticism and conviction, between examination and result, and between personal doubt and collective commitment. As statements of belief are offered as 'a philosophy', so prescriptions for professional conduct are offered as 'ethics'. But the apparent certainty, conviction and commitment implicit in such statements must hinder to some extent a genuine philosophical enquiry in nursing.

Although some transatlantic nurse writers have begun to move away from nurses' traditional misrepresentation of 'ethics' in the form of codes of conduct or even just as points of etiquette (Davis & Aroskar 1978, Steele & Harmon 1979), these are very recent attempts which have not yet been emulated in this country, with one exception. In a paper concerned with the question of honesty in nursing practice (Schröck 1980), I attempted an examination of some of the principles which appear to, or perhaps ought to, govern nurses' decisions to lie or tell the truth. The fundamental expectation of truthfulness in social and professional interactions makes it necessary to examine the nature of excuses and justification put forward to defend a deliberate deception in a professional relationship. This paper is reproduced in Appendix I.

But this and the above mentioned American attempts are still overshadowed by recent publications by professional bodies[3] which perpetuate this misrepresentation, and which are much more likely

to be in the hands of nurses than the few texts devoted to a more valid examination of the meaning and relevance of nursing ethics in relation to nursing practice.

One debate which engages a number of nurses (and other health care workers) is concerned with 'the rights of patients'.

The conception of human rights in a context which must imply a particular view of man and society, is embedded in the rise of individualism, and in the development of social contract theories in the seventeenth and eighteenth centuries, which held as their most fundamental and common tenet the principle "that the basis and end of government (is) the security, the happiness, the rights of the individual." (Kamenka & Tay 1978)

The ensuing declarations[4] which expressed some human rights as ideals or demands served obvious political purposes and must be considered as political documents. But while these various conceptions of human rights were now purposefully applied to political issues, they had originated in religious conceptions, conflicts and martyrdoms.[5] The eighteenth century with its doctrines of the rights of man invited a new argument which for the first time based its reasoning on philosophical analysis rather than on religious convictions. Closely linked to the notion of natural rights which belongs to the realm of moral discourse, the whole idea of human rights is essentially a moral proposal.

> "The doctrine of human rights is a *proposal* concerning the morally appropriate way of treating men and organizing society. Like all such proposals that gain force and command respect, it is a complex proposal, attempting to present a systematic view of man and society, taking up associated empirical material, relating and ordering moral preferences." (Kamenka & Tay 1978)

I will therefore argue that a discussion of patients' rights should be part of professional ethics in its proper sence, that is, prescriptions relating to patients' rights should be examined in such a way that the nature of the moral judgment required by the nurse in deciding on the 'right' nursing action becomes clear and explicit.

Davis and Aroskar (1978) offer a general discussion of the development and of the nature of human rights, examine the more specific right to health, and illustrate the conceptual and moral issues attending the notion of patient rights by examples of various declarations, such as the American Hospital Association Statement on a Patient's Bill of Rights, Your Rights as a Patient at Beth Israel Hospital Boston, and The Pregnant Patient's Bill of Rights.

It is pertinent to note that such declarations from various sources abound and can readily be found in the North American nursing literature. A perhaps particularly topical example in this, the United Nations' Year of Disabled People is the Declaration on the Rights of Disabled Persons (1976). But no such declaration has been fully reproduced and discussed in the British nursing literature.

Steele and Harmon (1979) treat the topic of individual rights in a somewhat narrower sense by concentrating mainly on the patient's right to refuse medical treatment or specific medical therapies, and on the right to confidentiality. As an analysis, their treatment is superficial, but in a descriptive way it draws attention to a variety of writings which provide such analyses in relation to the enumerated topics and situations.

In developing a moral argument in support of a theory of respect for persons, Campbell (1975) examines issues relevant to the idea of patients' rights, and discusses the rights of the individual in the context of an examination of utilitarianism.

With the emergence of patients' rights into the consciousness of nurses and other health care workers (and of patients themselves), it has become obvious that the moral proposals which are articulated in the declarations of such rights are not necessarily realized in action.

The original idea of human rights which defined certain areas of human conduct and affairs to be immune from government interference, also embodied the notion that the people could use justified force against the government, if their rights were not protected by governmental action. (Popkin *et al* 1956)

One important feature of both legal and moral rights, it seems, is their connection with coercive power.

> "Early declarations of rights were regarded as justifications for revolution and other acts of political violence." (Kamenka & Tay 1978)

John Stuart Mill (1962) declared it an injustice to take or withhold from any person "that to which he has a *moral* right." He believed that

> "When we think that a person is bound in justice to do a thing, it is an ordinary form of language to say, that he ought to be compelled to do it. We should be gratified *to see the obligation enforced by anybody who had the power.* ... When we call anything a person's right, we mean that he has a valid claim on society to protect him in the possession of it, either by the force of law, or by that of education and opinion." (the italics are mine)

But not all human rights enjoy protection by legal enforcement, or by the force of public opinion. The declarations of the patients' rights have remained clearly attempts to "put the desires and needs of patients on firmer ground and to bring them to the provider's attention". (Jenny 1979)

Writers on the subject agree generally that the adoption of a proclamation of patients' rights is the first important step, but that this by itself is not sufficient to guarantee thesc rights. Eventually, so Annas (1975) believes, following a period of education,

> "doctors and nurses will begin to afford patients their rights as a matter of course. Until this goal is attained, however, it will be necessary to set up some mechanism that can help ensure that patient's rights are protected. The mechanism I favor is the patients' right advocate."

Annas envisages a new kind of hospital worker who would represent the patient's interests and being only accountable to

the patient, would also have the power to enforce the realization of his rights.

Although Annas as well as Abrams (1978) and Kosik (1972) identified various advocacy models such as patient representative, counsellor, lay therapist, information provider, health care humanist (sic), watchdog, educator, spokesman, catalyst, and ombudsman, the proposals remained quite vague and nebulous.[6] Not so, however, the nurses' reactions!

The whole idea of patient advocacy received widespread endorsement in the North American nursing literature (Kosik 1972, Christy 1973, Pankratz & Pankratz 1974, Donahue 1978, Fay 1978), and quickly led to official statements by nurses' organisations (Registered Nurses Association of Ontario 1977).

In arguing for *their right* to adopt or to maintain the commitment to see patients' rights realized in the context of nursing care, nurses put forward coherent and searching arguments which demonstrated to me the ability of nurse writers *to examine the values* on which statements of patients' rights are based, and *to analyse the nature of the moral judgments required* by nurses in the realization of these rights. In other words, here unlike in almost any other context, nurses engaged in a valid philosophical argument.

I cannot offer any explanation for this phenomenon. Its very occurrence, however, makes other, often confused, irrelevant or arbitrary efforts to engage in philosophical enquiries so much more inexplicable.

Although modern moral philosophers tend to leave the discussion of what a good society should be like and by what criteria it might be recognized to some of their colleagues who are more directly concerned with the apparently distinct problems of political philosophy, it seems to me that these cannot be divorced entirely from the concerns of the moral philosopher. Neither do I think it very important for the purpose of my argument here to distinguish between political and social philosophy. (Flew 1979)

But it seems pertinent to ask whether nurses indicate in some way that notions like freedom or liberty, authority, power, obligation, consent, and justice have any relevance to their activities.

Campbell (1978) offers an examination of the concepts of freedom, equality and fraternity in a variety of political theories (such as social contract theories, utilitarianism, Kant's transcendental idealism and Marxism) in order to elucidate the problem of justice in the delivery of health care.

A multidisciplinary working group which included two nurses among its fourteen members and which also had the services of a nursing adviser, conducted a moral enquiry into the ethics of resource allocation in health care by group study over a period of two years. (Boyd 1979)

The group operated under the aegis of the Edinburgh Medical Group as part of a research project in medical ethics and education. The working group's purpose was to examine the moral criteria

which, either implicitly or explicitly govern or should govern, political and managerial decision making in the allocation of scarce resources in the health services of this country.

Griffin (1980) who, like Campbell, is not a nurse, emphasizes "the central importance ... in the area of moral concern" that a consideration of care priorities should be given. But nurses do not seem to have contributed greatly to this, in any case still rather limited debate.

I am deliberately omitting a close scrutiny of American papers related to these issues, since very few have been written by nurses, and those that seem to incorporate a nursing perspective tend to be descriptive or prescriptive rather than analytical. For example, Mullane (1975) deals with a popular subject when she describes how nurses can influence policy decisions, whether in governmental or local health care settings.

My own contributions (Schröck 1974, 1977a, 1977b) are rightly categorised as illustrating a suitable approach to the "proper content for general political education in a democracy" (Griffin 1980) rather than as analyses of political concepts and theories. The few passages in my papers which contain the seeds for an analysis of some notions like individual versus state responsibility (1974) and political consciousness (1977a), and which suggest a more critical examination of politics and professionalism (1977b) have not, to my knowledge, been taken up and developed more fully by other nurse writers in this country.

As I search for evidence of nurses' concern with moral issues in nursing, and of attempts on their part to analyse some central moral concepts and theories, I wonder whether such activities are essentially part of discovering the new kind of *nursing* knowledge which nurses say they need.

Might it not be sufficient for nurses to refer to the writings of others who examine moral problems in the context of health care, and who analyse and define ethical criteria of social and political relevance? Must nurses repeat the efforts of members of other disciplines in their search for knowledge? Perhaps they can use for their own purposes what others have found to be true, or apply the arguments of others to their own moral problems. It may be reasonable to suggest that the scarcity of writings about ethics by *nurses* indicates that these are simply not needed.

This possibility raises a fundamental question which has hovered constantly in the background of my argument and to which I have only intermittently addressed myself. It now seems necessary to be more explicit.

To what extent is nursing a composite applied science which draws on other disciplines for purposes of its own?

I have said that nurses may well use the results of scientific enquiry without participating in or repeating the experiments or observations which have produced these outcomes.

I also claimed that nurses need to *participate* in philosophical enquiries but I do not think that I have clearly shown why this should be so.

In questioning the 'truth for nursing' of some enquiries in other disciplines, I have maintained that the knowledge which results from a valid and reliable investigation may well be of use to nursing, but that nursing would not necessarily endeavour to identify and create its own knowledge in exactly the same way.

I suggested that the contents of nursing knowledge can only be defined after nursing has been conceptualized (that is, the contents of this knowledge must be secondary to its forms).

If some, or all, of these contents were to come from other disciplines, I wondered by what criteria items of knowledge may be selected in order to be applied in, or to be synthesized for nursing.

I tried to show that knowledge from the physical, biological and behavioural sciences does not become *nursing* knowledge simply by its application to nursing.

I have suggested that *nursing* knowledge might be identifiable by an explicit nursing perspective, by being structured and organised around a clearly articulated concept of nursing, and by its demonstrable potential to improve patient care through nursing action.

I do not imply by offering these criteria for *identifying nursing knowledge* that, for example, physiological knowledge about

the maintenance of body temperature that is applied by nurses might not improve the patient's well-being through nursing action. Neither is the question which was put to me, whether it is any worse for the patient, if this knowledge remains clearly biological science knowledge, relevant to the issue.

It may not matter at all *to the patient* whether there is such a thing as identifiable *nursing* knowledge provided that such knowledge as is used by nurses contributes to an improvement in his or her well-being. Moreover, it should certainly matter to patients, if there were potential or actual knowledge that could contribute to an improvement in their well-being but which is not being used by nurses.

However, it clearly matters to *nurses* whether there is any identifiable nursing knowledge, for the very reason that its systematic application in nursing care might improve the patient's well-being. Until it can be shown that there is no such thing, or if there is, that its use makes no difference to the outcome of nursing actions, it appears provident to continue the search for it. And it is this which is under discussion in my argument.

The observation that conceptualizations derived from other disciplines do not as such belong to nursing and can therefore not be readily ordered into a unified form or structure that is unique to nursing, is not made regretfully, as has been suggested to me.

If nursing can operate effectively without any conceptualizations of its own, and without ordering its knowledge base in some way that is meaningful to nurses, then the assertion that nursing knowledge is not simply a mix of other sciences is obviously irrelevant.

If nurses cannot operate as effectively as they might wish without conceptualizing their activities and without identifying *nursing* knowledge, then the observation that they need to go beyond the conceptualizations derived from other disciplines may cause quite another regret, namely that it needed a lengthy argument to arrive at such a fairly obvious conclusion.

A common observation about the nature of nursing is that like other professional activities (for example, medicine and education), it applies scientific knowledge to its own purposes and actions. Its knowledge base is therefore often described as a 'mix of other sciences'.

Illustrations of this conception of a mix of sciences usually involve representations of the sciences relevant to the centrally placed activity under discussion, as one example here may show:[7]

Leaving aside a number of problems apparent in this presentation (for example, it may not show all the disciplines which make up the profession's knowledge base, it does not indicate the proportions of each discipline's contribution, it assumes certain relationships between disciplines, and it includes dissimilar elements), the crucial question is: how does nursing apply these disparate items of knowledge, and is there anything which will make the final mix distinctive from other such amalgamations? Or to put it another way, what happens at the interface of these various disciplines with nursing?[8]

McFarlane (1976a), like many other authors concerned with this question suggests that, for example, the same item of

physiological knowledge would be applied differently by a doctor and by a nurse. This would also happen with other items of knowledge and would therefore lead to a different applied science for each profession. But what leads to this difference in application, and does the difference lie only in using the same kind of knowledge in a different way?

Professions which apply knowledge derived from other disciplines have in common that their activities serve a quite specific *purpose*. (Wiedenbach 1964, McFarlane 1976b) Without having to argue the point at length, one may expect that doctors, teachers, nurses, ministers, and lawyers pursue different purposes with their activities, although they all conduct these activities in personal interactions with a person or a group of people.

In pursuing their different purposes, each profession will select such knowledge from other disciplines as may be relevant to the *specific problems* that need to be solved in order to accomplish the set purpose. The mix of sciences which is utilized by a doctor is therefore quite different to that utilized by a nurse. Each must be unique to the purposes and problems of either medicine or nursing.

But in order to produce this unique mix of knowledge, the doctor must be able to conceptualize her purposes as a doctor, and she must be able to identify what constitutes a medical problem. She must do both these things in the context of the

practice of medicine which alone provides the basis for a conceptualization of its purposes, and allows an identification of the problem in medical terms.

That this also applies to nursing, and how its purposes and problems may differ from those of medicine may be made clearer by a rather simplified concrete example:

PATIENT'S EXPERIENCE :

extreme breathlessness

	PURPOSE	PROBLEM
PATIENT	to eat lunch	too breathless to eat
NURSE	to help patient to eat lunch	to identify factors increasing/decreasing breathlessness (including doctor's intervention), and appropriate means to help patient to eat
DOCTOR	to remove cause of breathlessness	to identify causes of breathlessness and appropriate means of medical intervention

Even if one assumed (probably quite unjustifiably) that both doctor and nurse will apply similar knowledge of the physiology of respiration to the solving of their different problems, the doctor, in addition, might draw extensively on her knowledge of pathology, biochemical action of drugs, microbiology, and radiology (physics), while the nurse may need more immediately knowledge about psychological and social aspects of eating, nutrition, anatomy and physiology of digestion, and the effects of movement,

gravity and air currents (physics). The nurse may even have to consider to what extent he is entitled to persuade or force the patient to do something which the patient clearly does not wish to do (ethics).

It seems clear that nursing is a composite applied science which draws extensively on other disciplines for purposes of its own.

Furthermore, the selection of knowledge from other disciplines must not occur randomly, if its application is to be of benefit to the patient.

Knowledge derived from other disciplines is only relevant to and applicable in nursing when it can serve the *purposes of nursing*.

Knowledge becomes *nursing* knowledge when it is selected and integrated for the purposes of *nursing* actions, and when it aids the solution of *nursing* problems.

The thought processes which are indicated by words like 'select' and 'integrate' demand a conceptualization of nursing purposes and actions.

Such conceptualizations, unlike the results of the empirical sciences, cannot be provided by other disciplines.

Therefore nursing is an applied science only to the extent to which nurses can use the results of the empirical sciences

within a conceptual framework of nursing.

Philosophical enquiries which might assist in such a task in nursing must be conducted by nurses since conceptualizations of nursing by non-nurses may be at best approximations and at worst distortions. This does not exclude that nurses might wish (and perhaps ought to) consider the perceptions other people have of nursing (especially patients).

Nurses may well learn from philosophers how to set about such endeavours, but philosophers unlike chemists or physiologists cannot provide the results (answers) for them to use.

Therefore it is necessary that nurses *participate* in philosophical enquiries, even if they need not participate in the actual research activities related to empirical enquiries in other disciplines.

The question which started this examination of how nurses may use the results of other disciplines can now be answered.

If moral discourse is concerned with the examination of values, the justification of moral statements, and an analysis of how moral judgments based on these values and statements are made, then nurses must engage in moral arguments. Only nurses can identify with any certainty the values which are pertinent in nursing. They must examine their own moral statements and justify the moral decisions which they make. The lack of such writings by nurses is not adequately filled by other people's legitimate concern with nursing ethics.

The foregoing discussion of nursing as an applied science is particularly pertinent to the kind of philosophical enquiries which I shall present as a final example of the use of philosophy in the nursing literature.

A vast transatlantic literature has emerged which one might globally describe as contributing to 'nursing theory'. Since I have not set out in this argument to analyze, compare and create nursing theory in particular or in any specific form, and since almost all of this literature is not directly and readily accessible to the majority of British nurses and nurse teachers, I shall select examples only to illustrate the kind of work that is being done.

To order this attempt in some way, I shall follow a pattern which might reflect to some extent the process by which the theory of a discipline is created and becomes established. In using words like concept, model, conceptual framework, and theory, I shall endeavour to explain my understanding of them for the purpose of this discussion. I shall not attempt, nor would I intend, to offer precise, invariant, operational definitions. Not only could I not accomplish such a task, it would be inimical to the purpose of any philosophical argument or enquiry.

> "The view that language is, or should be, or could be exact is one of the naif assumptions imported into nursing by nurses dealing with equally naif social or natural scientists or even philosophers. ... language is a much more living tool than is suggested by the outlook on language that links a given word to just one clear and exact meaning and sees any variation only as inexactness or misuse." (Dickhoff & James 1971)

I agree basically with Dickhoff and James in this respect, and I also share their fears that nurse researchers might engage in rather sterile undertakings as a consequence of elevating the measurability of a phenomenon to an end in itself rather than seeing it as a means to find answers to human concerns. This, however, does not exclude the necessity of judging when terms need to be defined more precisely and when they can be accepted in more global forms.

Although researchers who use empirical forms of enquiry need working definitions (or operational terms), they often fail to acknowledge that "many important terms lose something in being operationalized." (Stevens 1979)

The insistence on a definition of terms acceptable to all participants would in any case be counterproductive in a philosophical enquiry which sets out to question rather than to answer with finality. It needs tolerance for a certain degree of ambiguity to *explore the potential* of a given thought, action, or concern.

Having participated in two major enquiries which aimed at establishing a conceptual basis for nursing and for health visiting (Scottish National Nursing and Midwifery Advisory Committee 1976, 1981; Council for the Education and Training of Health Visitors 1977, 1980), I would suggest the following steps as a feasable progression in theory construction in nursing:

- the identification and clarification of pertinent concepts elucidated from current nursing practice which may include attempts at definitions of nursing or health visiting

- the attempt to relate key concepts by experimenting with various models and applying them to nursing or health visiting practice in order to test their explanatory value and power for practice

- the construction of a conceptual framework

- the formulation of principles (in the form of hypothetical generalizations or theories).

The formulation of a principle opens the way to empirical investigations of the conditions under which a particular principle does or does not hold.

> "As evidence of the validity and reliability of a principle accumulates, its value as an empirical tool is enhanced. Commonalities between events come into view. The significance of a principle may take on new dimensions of meaning beyond those envisaged by the formulator of the principle. Principles are symbolic. They are representations of the real world and must be tested against actuality to verify their correctness." (Rogers 1970)

It is from *within* a conceptual framework for nursing that testable hypotheses which have relevance to nursing are derived. Empirically established facts, and ideas expressed within such a framework, are synthesized to present a coherent pattern consistent with known nursing practice. Or to put it another way, the frame of reference provided by a conceptual system which utilizes the key concepts thought to be central to the practice

of nursing, and which relates them to one another in a dynamic model of nursing practice, allows empirical observations to be organized into a meaningful whole, that is, into a body of knowledge.

> "The science of nursing[9] is a body of abstract knowledge arrived at by (empirical) scientific research *and* logical analysis. It is this body of knowledge that encompasses nursing's descriptive, explanatory, and predictive principles indispensable to professional practice in nursing." (Rogers 1970 - the italics are mine)

However, if the impression were created that only those facts which 'fit' into a preconceived conceptual framework were admitted as being valid, then it is vital to emphasize the interrelationship between these two (but by no means distinct) parts of a theory.

What I chose to call a conceptual basis for the development of nursing knowledge is only *one*, but an essential part of what might become a theory of nursing. Empirical investigations (which establish facts by a variety of methods) must be grounded in the conceptual basis but will in turn modify, elaborate, and extend, that is, *change* it.

Once this interrelationship is clearly established, one might be able to distinguish between the initial act of theory building (construction) and the refinement of theory following empirical investigations (development), as Stevens (1979) suggests.

Some attempts have been made to examine the process of theory construction. All but two of these contributions belong to the

transatlantic nursing literature.

These contributions tend to pursue slightly different ends. There are those which advocate theory construction as a worthy and useful undertaking for nursing (Foley 1971, Chapman 1972, Johnson 1974), those which examine how to set about the task (Hardy 1974, Jacox 1974, Dickhoff & James 1975, Schröck 1977)[10], and those which try to illuminate the content and premisses of nursing theory construction and development (Phillips 1977).

All these approaches are important.

While articles which are entirely devoted to the advocacy of theory construction by offering reasoned and detailed arguments for such a stance, were more numerous in the 1950's and 1960's in the North American nursing literature than they are now, Stevens (1979) claims that the need for them remains since "many of our nurse leaders still claim that theorizing is not appropriate for nursing."

As she rightly points out, "there is little choice about whether or not to theorize." One does so of necessity, the only difference being whether or not one may recognize the theoretical base from which one acts and reasons.

The absence, by and large, of any such consistent and coherent advocacy of theory construction in the British nursing literature is surprising and difficult to explain, since research papers of all kinds have proliferated in nursing over the last

two decades. Although almost all nurse researchers endeavour to present a clear account of the theoretical base of any other discipline which underlies or contributes to their work, few researchers seem to recognize the need for an articulated conceptual basis which is derived from a nursing perspective.

I can only hazard a guess that the tendency to underplay the value of nursing theory springs from a fear that the still early development of nursing as an academic discipline will be rejected outright by the nurse practitioner, who, it is assumed, simply wants practical answers to practical questions, and does not see the need for 'theorizing' about nursing.

There may be some justification for this assumption when one considers the traditional values which find expression in stereotyped 'feminine' behaviour in what was, and still is, largely a women's profession; that anti-intellectualism was, and still is, characteristic of the 'sisterhood of nursing', and may still be reinforced by the equally stereotyped expectations of a 'brotherhood of medicine', has been observed and documented by many writers (for example, Reinkemeyer 1969, Dickhoff & James 1970, Partridge 1978).

I think, however, that also other factors influence this apparent unwillingness of the practitioner to accept the idea that a conceptualization of nursing is a prerequisite for effective nursing practice as well as for valid and relevant nursing research.

Ellis (1970) observes that

> "The orientation of the nurse scientist to nursing, and to the practice and practitioner in nursing, is essential, if one wants to use the word "nurse" to modify "scientist", or to use the word "nursing" to modify the word "research" *Pressures for some discontinuity with nursing can occur in the process of a nurse becoming a scientist.*" (the italics are mine)

It seems possible that nurse researchers experience a certain loss of identity as nurses in "the process of acquiring identity with and from an academic discipline." This might also contribute to their inattention to theory construction in nursing.

Another point made by Gamer (1979) is also worth considering in this context. It may well be that practitioners and nurse researchers no longer share a common nursing perspective, that is, they each have a very different '*Weltbild*' of nursing.

I have argued elsewhere that any conceptual revision in a practice discipline must be shared with the practitioner, and that answers which are offered by the researcher, may not be acceptable to the practitioner for a variety of reasons (Schröck 1977c, 1981) But none of this really solves the two major problems, as I see them, that appear to hinder the work of theory construction in nursing.

Firstly, practitioners do and must 'theorize' whether they are aware of it or not. The questions, inherent in this problem of non-recognition of 'theory' are, how practitioners can be helped to articulate their thoughts, and how the 'superiority' of one kind of theory over another might be argued.

Secondly, the results of nursing research will not be widely applied until the problem of a conceptual framework for nursing is solved to some extent, and any emerging framework is shared by both researchers and practitioners at least in its most fundamental conceptualizations.

The contributors who examine how to set about the task of theory construction appear to be unanimous in the view that this is a process which proceeds through various levels or stages These level are identified differently by various writers but they generally include as a first stage the identification, examination and classification of concepts which appear most pertinent to the activity under discussion (or, as Jacox, 1974, suggests, which are used in describing the phenomena in the field).

The probably best known account of the development of a personal concept of nursing is that by Henderson (1966). The resulting definition of nursing, that is

> "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.",

has become almost as famous as the World Health Organisation's definition of health which describes health as a state of complete physical, mental and social well-being, rather that solely as an absence of disease. Henderson's definition of nursing is quite often, but not so often applied with any consistency in either argument or practice. This may be due to its apparent simplicity (which is usually a sign of a clearly thought out statement,

and should be taken as a credit). Henderson herself acknowledges that

> "This concept of the nurse as a substitute for what the patient lacks to make him "complete", "whole", or "independent" by the lack of physical strength, will, or knowledge, may seem limited to some."

But on closer examination of Henderson's reasoning leading to her definition of nursing, the apparent simplicity soon gives way to a whole array of concepts which are now claimed by many nurses to be fundamental to professional nursing practice (for example, patient-centred care, patient needs, activities of daily living, independence, nursing problem, help, patient participation, and many more).[11]

Henderson does not claim to have invented these concepts and pays tribute to a great many sources of inspiration. But she does present her conceptualizations as a result of what Stevens (1979) would call singlehanded development of nursing theory.

I do not know of any writers who identify and examine concepts derived from observed or experienced nursing practice without attempting to order them in some kind of model which can be tested in its application to nursing. It seems that the first two stages of the task of theory construction are so closely linked that one cannot really be performed without the other.

But it is pertinent to note that, frequently, those writers who present more elaborate models are far less explicit about their

conceptual components than is Henderson who utilizes only a simple need-and-response model to illustrate the relationships between the concepts which emerge in a lengthy argument.

Although Rogers (1970), for example, devotes a great deal of time to the explanations of evolutionary, cultural, scientific and philosophical conceptions of nature, man, and the world, her exploration of those concepts most pertinent to nursing is very brief. I do not think it enough to say that a conceptual framework for nursing must take all the foregoing into account. Even if nursing science must build on basic assumptions about the nature of man, such as his 'wholeness', his interchanges with his environment, and his inevitable progression from birth to death, it cannot operate with *all* the details offered by Rogers without transforming them into manageable concepts that can be utilized within a nursing perspective.

Schlotfeld (1971) confirms my reservations about Rogers' global approach. She says,

> "Even though attempts to develop grand theories of the life process of man are ongoing there is as yet no verified science that leads to the understanding of all behaviour of human beings."

She implies, I think, that it is hardly up to nurses to produce this global understanding of man and his world but that intelligent nursing action might result if practice were guided

> "by theoretical constructs about man's health - seeking and coping behaviour"

and, one should add, if such theoretical constructs included a conceptualization of *nursing* interventions

> "that have predictable chances of augmenting the health-seeking behaviour of individuals and groups."

Before further examining contributions to the use of models in nursing, it would help me to think about their meaning generally and about their use in the construction of nursing theory in particular.

Some people do not like models, or feel that they are misused in some way, but they fail to say why or in what way this may be so. (Crow 1981)

Models like conceptual frameworks, theories or other kinds of analogies, are *representations* of something that exists, happens, or in some way manifests itself in the real world which we experience. They are organising devices by which we can orientate ourselves in thinking about complex phenomena. In that aspect all these representations are alike.

In distinguishing between, for example, models and conceptual frameworks for nursing, as I have done and as many authors on the subject do, one introduces a property of such representations which may vary in degree, and this is the commitment one has towards them as intended factually true representations, or the degree to which one believes them to incorporate the most salient aspects of the phenomena which they purport to represent.[12]

I see models as constructions (verbal, figurative, or symbolic) which relate key concepts in nursing in a variety of ways. They serve as *means of experimentation*, of trying out one, then another relationship between concepts and testing them against the practice from which the concepts emerged. They may provide the necessary means for rearranging certain key concepts for specific purposes within a given conceptual framework.

In other words, the commitment to a particular model is, and probably should be, somewhat ephemeral, if one considers it to be a means of conceptual or paradigmatic experimentation in which one tries out, accepts and discards various elements of a usable model which must be tested for its inherent consistency and for its explanatory value and power in relation to the practice under examination. But there is a danger that conceptual experimentation can be prolonged to such an extent that the original relationship which a model was meant to illuminate, has got lost altogether.

There is no perfect model!

The search for it is an illusion based on a misunderstanding of the function that a model can serve. It may well be that the best model is the one which holds together long enough to allow for a better one to be developed. (Schröck 1981) The use of models as experimental devices is very clearly illustrated by Chapman (1975) in examining how the pattern of nurse education could be reconsidered in the light of some of the recommendations of the Committee on Nursing.

However, the next step in theory construction as I have envisaged the process, would be a far more committed action which leads to an acceptance, for the purpose of generating hypotheses or principles, of a more permanent and also more elaborate conceptual framework which contains elements tried out in a variety of models and found to be valid at least at that stage.

An example of a conceptual framework for nursing which builds on Henderson's work with reasonable consistency, is provided by the Scottish National Nursing and Midwifery Consultative Committee (1976), and its extension (1981) shows how the working group concerned with a "further exploration and with ... validating (the Committee's) own concept of nursing and translating it into practice" utilized the work that had already been done by its predecessors in the Committee. It is useful to recall Chapman's contribution here, as she makes an observation which illustrates the relationship between models and conceptual frameworks in nursing. Models, she argues, may act as tools *within* a conceptual framework such as the nursing process which is a central component in the representation offered by the SNNMCC's working group. One could argue with some justification that any kind of conceptual framework tends to take on a less dynamic character than that inherent in the conceptual experimentation which the use of various models facilitates. It is not yet for me to say how the various models suggested by Chapman (for example, the medical, an open systems, a need-response, and a social exchange model)[13] might provide a dynamic dimension to a conceptual framework of nursing such as the nursing process presents. But since the nursing process

is a linear (or possibly circular) model itself, one may appreciate that it might need various other directional extensions to give it some purposeful impetus.

Although some writers like Henderson do not extend very far into the third stage of theory construction (that is, the construction of an explicit conceptual framework), this stage does seem to be very closely related to the first and second levels of theory construction, so that most authors concern themselves with all three of them. Sometimes it is therefore difficult to decide which stage has actually been reached, especially if the author does not employ a figurative or symbolic representation of modelling or framework construction.

No such difficulty exists in identifying when theory construction has reached the stage of the formulation of principles since this seems to be seen as a quite distinct activity.

Some authors propose principles which could well lead to the formulation of testable hypotheses without deliberating on a clearly identifiable conceptual framework to any great extent.

Wiedenbach (1964), for example, bases her "principles of helping" (that is, the principles of inconsistency-consistency, of purposeful perseverance, and of self-extension) on an ideological exposition which incorporates some moral concepts (such as respect for life, for the dignity, worth, autonomy and individuality of man, and moral commitment and courage) and some general assumptions about the nature of man. She uses a need-

response model similar to Henderson's, but it is not really clear in what way the proposed principles relate to all these, still disparate elements.

Having already criticized Rogers' limited exploration of concepts which may be especially pertinent to nursing, I can however appreciate how principles such as reciprocy, synchrony, helicy, and resonancy can be derived from the wide-ranging discussion of the nature of man and the world, but I am not very sure how or if they can be derived from a conceptual framework of nursing.[14]

In the British literature, principles have only emerged from the investigation carried out by the working group of the Council for the Education and Training of Health Visitors (1977). Defining the practice of health visiting and clarifying fundamental concepts utilized in describing that practice preceded a stage of conceptual experimentation with a great variety of models relating to various aspects of the process of health visiting. The value of health appeared to be *the* concept that informed, guided and linked almost all representations. Its detailed analysis was therefore considered to be of prime importance. The principles that were formulated, were derived from the agreed definition of health visiting practice and from the belief in the value of health. So emerged four principles which might best be described as the principles of searching for health needs, stimulating awareness of health needs, influencing policies affecting health, and facilitating health-enhancing activities.

There is one major difference which becomes apparent in comparing the far greater literature devoted to nursing theory in North America with the very small British contribution. Almost all theory construction presented in the transatlantic literature is carried out by individual nurse theorists. McFarlane (1980) provides a very useful analysis and comparison of four prominent individual contributors: Imogene M. King, Dorothea E. Orem, Martha E. Rogers, and Sister Callista Roy. King (1968, 1971, 1975) and Roy (1970, 1971, 1973, 1974) in particular are representative of those nurse theorists who have developed their own theory constructions over a number of years.

Stevens (1979) dismisses frequent attempts to construct theory by a group process as unproductive, as "there is no major nursing theory that is the result of 'group think'."

She notes the constraints which appear to hinder successful group work in this field. At conferences, symposiums and other such short lived groupings, people to not have time to explore each others' views, to argue constructively about differences, to develop a feeling for the enterprise in hand, to learn from one another, and to tolerate the unstructured, uncertain nature of the experience since inevitably there are 'programmes' to be followed and 'results' to be produced. The only outcome is likely to be what Stevens calls a "theory by negotiation", and she concludes that "theory construction as a political act is unlikely to result in a consistent, coherent product."

On the other hand, Stevens acknowledges the difficulties of theory development since

> "An active exchange of ideas through critique of theory work is the exception, not the rule. The nursing ethos of noncritical acceptance for the work of others acts to the detriment of the discipline. Few theorists receive any serious criticism from their peers. Thus, few get assistance in developing their ideas. ... In addition, there appears to be a nursing ethos that a theory, once evolved, remains the 'property' of its originator."

It is not difficult to see that there are two major problems associated with the singlehanded development of nursing theory. One is that such a diverse and disparate range of approaches makes it impossible to see any unifying or complementary characteristics which would help the teacher, researcher, and not least of all, the practitioner to use the proposed theories in their work and thereby provide the essential empirical dimension which is needed to create a body of knowledge by testing the hypothetical propositions expressed in these theories. If, nonetheless, researchers provide empirical verification or falsification in relation to these many diverse approaches, then the fundamental task of integrating and structuring the knowledge so derived can still not be accomplished, if one assumes that a theory should allow empirical observations to be organised into a meaningful whole, that is, into a body of knowledge.

Empirically established facts, and ideas expressed in such a diversity of conceptual frameworks, cannot possibly be synthesized into a coherent pattern consistent with known nursing practice.

This is not to dispute Stevens' claim that the great drive for a universal, unitary nursing theory is an obstacle which has serious detrimental effects. But although one would not wish, as she says, like to see psychological theory represented only by Freudian conceptualizations, one can nevertheless discern a fairly common, generally valid conceptual framework in which all psychologists operate and to which they refer. For example, a Freudian analyst and a Skinnerian behaviourist can communicate with comparative ease about a psychological phenomenon, such as trust or maturity, which is set in a developmental context, since they both accept that the investigation of developmental processes is part of the essential business of psychologists. They share a conceptual framework *within* which they can propound different theories in the form of different propositions, assumptions and hypotheses. There is no need to develop a "grand theory", but there must be some shared understanding of how various theoretical approaches are to be interpreted within conceptualizations which are meaningful to all members of that discipline. It therefore seems to me that some *shared* attempts at theory construction and development are not only desirable but necessary, if a certain degree of coherence and consistency is to be achieved.

This brings me to the difference apparent in the few British contributions to the topic. Apart from the articles which advocate theory construction and examine how to set about it, two major contributions to the endeavour to construct a conceptual basis for nursing care and health visiting were made by working groups set

up for the purpose.

That these collective efforts resulted in reasonably coherent expositions may well be due to certain circumstances which seem to have lessened the constraints identified by Stevens as being detrimental to any successful outcome of such undertakings. It must be noted that both groups worked without a time limit. (CETHV 1977, SNNMCC 1981) Although the composition of the membership of the groups changed from time to time, there was remarkable continuity in membership which undoubtedly facilitated a learning process for those involved in the deliberations. Not least of all, both groups had the advantage of being able to draw on a cohesiveness derived from external factors. In the case of the health visiting group, the closeness of a numerically small profession allowed an intensity of communication and collaboration which would not be possible, if for example, all general nurses attempted such an exercise. The Scottish group undoubtedly benefited from the cohesiveness of a geographically small country and from a distinct identity of a numerically small professional group.

The results of their work so far, modest as these may be compared with North American endeavours, promise a reasonable coherence and consistency without appearing to 'shut out' diverse and individual contributions to the further development of a conceptual framework capable of fulfilling the organising and ordering function without which the practitioner cannot utilize the emerging results of empirical investigations which should inform, direct and explain his practice. Perhaps true to the

assumed British talent for compromise, the tendency seems to be to develop neither the "grand theory" (such as Rogers') nor a rather limited theory concerned with only a narrow range of phenomena (such as Wiedenbach's), but to construct "theories of the middle range" (Merton 1968) to avoid the disadvantages of both extremes.

I would like to close this discussion on the varying contributions to a construction of nursing theory with a speculation. I wonder, if the pioneering project, "The Study of Nursing" which was set up in this country in 1966 and produced twelve studies, "each exploring a particular aspect of ward nursing care" (Inman 1975), would have presented the Research Project Leader with the same difficulties in meeting her obligation "to coordinate and write up the entire project at the end ...", if a reasonably well articulated conceptual framework of nursing had been available to the project leader *and* the researchers *before* embarking on the work?

It is important to note that this approach to what the introductory monograph to the series had called "the proper study of the nurse" (McFarlane 1970), did provide an exemplary opportunity for formulating nursing questions, investigating settings where nursing actually happened, and attempting to measure nursing effectiveness.

The argument set out by Inman is worth recounting, since it illustrates some of the fundamental problems inherent in the

endeavour to produce nursing knowledge.

All the studies set out to produce indices or criteria for measuring the quality of nursing care in a wide variety of settings and of a wide range of nursing activities.

Although "the main purpose of all was to describe and enlarge our knowledge of patient care", conceptions of nursing contributions to patient care which must have been held by the researchers before selecting "theories such as the theory of personality, theory of learning, skills and stress", and before "applying established techniques", were never made explicit or shared, it seems.

It is therefore quite possible that these conceptions differed in material ways. This is not to say that theories and investigative tools used in other disciplines could not have been employed in answering the nursing questions, if it could have been shown that they had relevant properties which could establish a relation of modelling to the conceptualization of nursing. As Wartofsky (1979) says, "anything may be taken as a model of anything else", but "not everything has the relevant properties which permit it to be taken as a model of something else". But since the relevant properties of pertinent nursing concepts, their potential relations and their potential explanatory value and power for nursing practice (the effectiveness of which was to be measured) had not been established, the scientific theories "borrowed" from other disciplines may not have been appropriate models. One point about representations (in which for the purpose of this discussion I am including models and theories)

that may have been especially pertinent is that a chosen model or theory may fail as an intended factual representation because it is richer in properties than the object, relationship, event or situation it is meant to represent.

> "We can hope that it is rich enough for us to continue to use it fruitfully as an instrument of enquiry about its object; but barring identity of model and object, it cannot be as rich at the limit and yet remain a model. *It must therefore be less rich in relevant respects than its object, which is precisely what we mean by characterizing it as abstractive.*" (Wartofsky 1979 - the italics are mine)

Inman attempted to synthesize the results of these studies in different ways. Keeping the nature of representation by models and theories in mind, since the chosen theories were not representative of anything conceptually germane to nursing, they could not "provide a valid framework for all 12 studies." (Inman 1975)

It becomes very clear that the search for a conceptual framework which would allow some organisation of the studies was a retrospective endeavour. In relation to one study, Inman asks,

> "as the author uses Cattell's I.P.A.T. is the study purely a psychological enquiry? Does it contribute to the theory of personality as developed by Cattell? ... what kind of study is this? ... if it is not a psychological study nor an enquiry into basic nursing could we perhaps call it a patient satisfaction study? ... Any attempt to label the study ... leads to absurd distortion of its true aims and focus."

Various attempts to analyze the studies by instruments or by ascertaining their contribution to nursing care and research failed, since, as Inman then says, "a list is no substitute for a *conceptual schema.*" (the italics are mine)

The model that is finally adopted is based on the central concept of "patient need". Its importance, says Inman, is that

> "it is possible to focus research directly on nursing care, instead of being forced to view it as, say, an intermediate variable in patient care, or as an aspect of hospital organization"
>
> and
>
> "if we wish to give a real meaning to the concept of *nursing* research we must find a way of researching into practical nursing care which makes it the centre of attention instead of an adjunct."

This is, I would argue, we must conceptualize from the practice of nursing as it appears to be and produce a conceptual framework of nursing practice from which the hypotheses and propositions for empirical enquiries are derived.

This indeed was Inman's conclusion, and proposals for nursing practice research based on a framework derived from "internally validated items", that is based on axiomatic assumptions about the nature of nursing care, were put forward.

This part of my argument has led me from the claim of nurse writers to a philosophy of nursing in the form of ideological statements which I hold to be a mistaken one, to look around for philosophical concerns in nursing which might be emerging in other contexts.

An obvious area to search in for an indication of the appropriateness and usefulness of philosophical enquiries appeared to be that of nursing ethics. Again I found it disturbing that conclusions appear to have been confused with questions. The

emerging notion of patients' rights offered another aspect of potentially valid philosophical enquiries, and it seems that in this context nurses have attempted to argue their case with lucidity and reasoned conviction. Closely linked to the concerns of the moral philosopher are those of the political and social philosopher. I found the relevant material in the nursing literature limited and by and large descriptive rather than analytical. It occurred to me to question to what extent nursing can function as an applied science, and what this might mean in relation to two very important questions, namely what nurses must do for themselves, and what they can apply for their own purposes in the form of results obtained by other disciplines.

These still seem to me fundamental questions, particularly in view of the extensive efforts of nurse theorists who are engaged in theory construction and development in nursing.

I would admit the possibility that nursing can function adequately without conceptualizations of its own, if it were possible to order and organise whatever knowledge nurses may need within an already existing theory so that this knowledge becomes readily identifiable to the practising nurse and is meaningful in a nursing context. The example which concludes my search for indications of philosophical enquiries in nursing does not remove the doubt from my mind that this is not possible and that the efforts of theory construction as a basis for empirical investigations in nursing is an essential one.

Throughout this second part of my argument I have done what I suggested nurses should not be doing in relation to their investigations into nursing practice.

By asking what indications there may be of the use of philosophical enquiries in nursing, and where these may be found, I must have had some personal conception of what might characterize such enquiries. I must have used some implicit criteria for judging some claims to a philosophy in or for nursing to be invalid. In other words, it is as impossible to talk about philosophy without some personal conception of what philosophy might be or is, as it is impossible to talk about nursing without drawing on a personal '*Weltbild*' of nursing. But just as people's ideas of what might characterize nursing are likely to be different, so the nature of philosophical enquiries may be seen in various ways by different people.

I must therefore examine how philosophers identify and explain the nature of their discipline, its methods, contents, activities and purposes, before I can suggest if or how philosophical enquiries might become relevant to or meaningful in nursing.

NOTES TO PART TWO

1 In a chronological sense, the division of philosophy into a classical, medieval, and modern period simply indicates the historical place of certain philosophers. For this purpose, classical philosophers are practically synonymous with the philosophers of classical Greece (including the presocratic and neoplatonic schools) between circa 600BC and 500AC. In classifying ethical theories in an attempt to draw attention to certain distinct features, an apparently historical division into 'classical' and 'modern' seems to suggest that classical philosophers have propounded a classical moral theory, while those who came later expanded on modern moral theories. But Thomas Hobbes (1588-1679) and Benedikt Spinoza (1632-1677) are in a chronological sense, modern philosophers. Moral theories are considered to be 'classical', if they attempt to answer one of two questions, or possibly both, namely 'What is the good life for men?' and 'How should men act?' Most classical theories do not distinguish carefully between these two questions. But is is easy to see that, for example, Christian ethics now as ever would be seen as classical moral theory since their purpose must be to examine and elucidate the good life for man which consists in the love of God, and by demonstrating how this good life can be attained by acting in accordance with God's laws. John Stuart Mill (1962) expounds a classical moral theory in examining the principle of utilitarianism, according to which "an existence exempt as far as possible from pain, and as rich as possible in enjoyments, both in point of quantity and quality" is the desirable state for people to attain, clearly answers the question 'What is the good life for men?' It is therefore right to say that classical philosophers were concerned with classical moral theories, but also, that some modern philosophers continue to examine moral principles in the context of classical moral theory.

2 Nowell-Smith (1954) distinguishes the theoretical from the practical sciences by ascribing to the former the task of providing statements, descriptions, generalizations, explanations and laws. He uses the same explanation for a theoretical philosophical discourse which would, for example, appraise the characteristics of goodness without any particular directive whether an action bearing these characteristics may be desirable or how a state of goodness might be achieved. Practical discourse, on the other hand, Nowell-Smith claims, would provide answers to such practical questions as 'What ought I to do?' The answers derived from a practical discourse would be decisions, resolutions, expressions of intention, or moral principles leading to an order, an injunction, or a piece of advice. Seemingly, Nowell-Smith assumes, as do others who make this distinction (for example, Feibleman 1958), that knowledge can clearly be separated from people's practical concerns.

But if "Philosophy is the methodical and steadfast attempt to bring reason into the world" (Horkheimer 1972), and if "the ultimate source (of philosophy) is the will to authentic communication" as Jaspers (1951) claims, then any philosophical enquiry must have the potential to contribute eventually to the "clarification and refinement of the conceptual world which we meet in daily and scientific life", and must educate some individuals for right thinking and acting. And if it does so, is Horkheimer not justified in his claim that all philosophy must have as its ultimate goal "the realization of the good, and (this means) the rational organisation of human society"? This is not a contradiction to seeing philosophy as "a disinterested pursuit, to which questions of utility ... have no relevance." (Jaspers 1951) It is disinterested in the sense that the philosopher asks questions regardless of the convenience or inconvenience that her questioning may cause to adherents of established or accepted ideas. Philosophy may not attempt to answer the questions which people with vested interests may wish to have answered. In this sense, it may appear to be of no immediate use. Philosophical enquiries like any other form of human investigation, "may rise into the rarified atmosphere of a hollow and bloodless idealism or sink into tiresome and empty phrase-mongering, (but this) does not mean that these are its true forms. As far as tedium and banality are concerned, philosophy often finds its match in the so-called investigation of facts." (Horkheimer 1972) Neither does the close relationship of theoretical and practical philosophy (if one needs to make this distinction) invalidate the often made claim that philosophers may not find better or different answers, or that there may not even be settled ways of arriving at answers. Whatever answers a philosophical enquiry may offer, if any, it would claim to have better reasons for them than can be found for those which are arrived at in the absence of a thorough rational examination and analysis.

3 The Royal College of Nursing of the United Kingdom published two such documents in 1976 and 1977. Its Code of Professional Conduct (1976) follows the International Council of Nurses' code in making "explicit those moral standards which should guide professional decisions in these matters". It is properly called a code of professional conduct and presented as a "discussion document". However, it is in this aspect that it does not fulfil its promise. The items listed under 'discussion' do not provide alternate views for discussion nor do they examine critically the reasons for adopting the principles which are articulated in the 'text' of the document. The 'discussion' consists of an explanation and elaboration of the aims which are expressed in this code in relation to the nurse's responsibility to patients or clients, for professional standards, and to colleagues and society at large. In the second document, Ethics Related to Research in Nursing (1977), the usual misrepresentation of ethics is even more obvious. Again intended as "guidelines for nurses undertaking or associated with research", the code claims as its rationale

that "the ethics of nursing research must be consistent with the ethics of nursing practice." This implies that 'ethics' are statements, the virtue of which lies in their consistency. In examining the nature of moral decisions in nursing research or in nursing practice, which would be the proper task of ethics, 'consistency' of this kind would be a somewhat irrelevant concept. The publication contains no indication of any critical analysis of its content, and refers the reader only to similar codes of conduct which have been issued by other professional bodies. These criticisms should not necessarily lead to the conclusion that codes of professional conduct must be elaborated into a moral discourse. This might well defeat their purpose. But by implying that they *are* the *ethics* of the profession, they inadvertently give the impression that this is all there is to ethics. It is not apparent that such rules for conduct may be the *outcome* of a searching analysis, nor is there any indication that they could and should be reappraised. The exhortation to discuss, which frequently accompanies these documents, is plainly geared towards an *application* of the guidelines but not towards an examination of their continued validity.

4 I am thinking here of the Declaration of Rights by the People of Virginia in 1776, The unanimous Declaration of the thirteen united States of America of 1776, and the Declaration of the Rights of Man and of Citizen prefixed to the French constitution of 1789.

5 The conception of the perfectability of man as man stands in contrast to the concept of man who can only find perfection in God. The prerenaissance idea of man in a familial, social and cosmic setting, transcended the individual and saw man as part of a structured community based on a common religious tradition, a hierarchy of power, and a network of mutual obligations, all of which shaped men's lives rather than served them. A vital influence, although not its exclusive cause, on the development of individualism were the struggles within the Christian church against papal absolutism and religious hierarchy, that is, the rise of protestantism as the affirmation of the individual conscience against church doctrine. But where the controversies of the fifteenth and sixteenth centuries had been conducted largely in the language of religion, the social contract theorists were doing something startingly new. They proclaimed that the constitution of society was not divinely ordained and serving some divine purpose. They claimed that men by their actions organised society which existed not for the benefit of God or King, but solely for that of the individual in society.

6 In discussing the problems accompanying the giving of informed consent especially in mental health care settings, Tancredi and Slaby (1977) suggest the setting up of a "patient-advocate committee of some variety"!

7 I am grateful to Lisbeth Hockey for allowing me to use this illustration which was devised by her, for my own ends. I must emphasize that she also acknowledges the limitations inherent in such a representation. Neither should any particular significance be attached to the apparently total inclusion of pathology and physiology into the field or set of nursing. If I were to 'experiment' with this conceptual model, I might imagine the various sciences and disciplines to be similar to chemical compounds set into a series of dishes which are wholly or partially covered by a specially impregnated and absorbent disc. By some means, like heat or motion, the disc will absorb certain elements from all these compounds in different proportions. In this way, only some elements would be absorbed even from those dishes which are entirely covered by the disc. Since, however, it is not my intention to justify this particular model in any of its specific aspects, but rather to offer it as a useful example of the *kind of representation* which endeavours to show this mix of sciences', I must not now divert myself with further conceptual experiments.

8 It may be pertinent to draw attention here to Stevens (1979) who observes that every discipline has similar boundary ambiguities but that the uniqueness of nursing does not lie in the fact that such boundary overlap exists, "but in the *number* of boundary overlaps with which it must contend. ... Nursing's unique problem is to find a way to adapt these numerous, unrelated, and potentially contradictory boundary theories to its own milieu and its own image of man."

9 In addition to all other confusions that the term science is liable to create, it also suffers from a process-product ambiguity. (Rudner 1966) Science as a process is concerned with the methods of developing and testing knowledge, while science as a product refers to the body of accumulated knowledge that claims to describe some aspect of our world. It is easy to appreciate that those who define the process of science as being synonymous with empirical enquiries, tend to accept only knowledge gained in this way as being the legitimate product which constitutes nursing science. But it should be clear from the discussion that a body of knowledge (which is organised, structured and meaningful) cannot be created by this version of 'science' alone.

10 As part of my contribution to an investigation into the principles of health visiting which was conducted between 1975 and 1981 by a working group set up by the Council for the Education and Training of Health Visitors for this purpose, I wrote a discussion paper for the members of the working group and officers of the Council. This paper was eventually published in an edited version in the working group's first report (CETHV 1977), and is reproduced in that version in Appendix II. In a document subsequently published (CETHV 1980)

which contained observations and opinions expressed in some of the debates and conferences which followed the publication of the report, Gregory offers an analysis of the situation which led to the exercise of reappraising the principles of health visiting. She points out, rightly, that the process of reappraisal was initiated by teachers of health visiting and not by its practitioners. However, the participants of the 1976 Nottingham Workshop *did* appraise the activity of health visiting and not the activity of teaching, as Gregory claims. Whether teachers of a professional activity who themselves are qualified to practice, are justified in asking questions about the practice of their profession, is another issue. I would certainly concur with Gregory that "the tutor must act as an educational leader ... by making the activity of health visiting determine the knowledge required rather than the other way round". How he or she can do this without examining and analyzing this activity, I do not know. There may indeed be "marked differences between questions raised by tutors about the practice of health visiting and questions raised by *practising health visitors* about the practice of health visiting." They may not reflect questions asked by practitioners but that does not make them 'wrong' questions as Gregory implies. It might however, lead to unconstructive situations, if no shared agreement between teachers and practitioners is reached about their meaning and about what might count as a relevant answer, as I have pointed out in a paper concerned with a variety of philosophical issues, which is reproduced in Appendix III. A most illuminating comment by the Health Visitors' Association which regretted the effect of the report in carrying "the risk of increasing rather than alleviating ... insecurity" illustrates my point that to solve the increasing uncertainty of a profession or a discipline, one must create more, and perhaps deliberately, total uncertainty, which is a frightening prospect for both the individual and the group. To those involved in the experience, it signified their first major achievement when they found themselves able to tolerate the uncertainty which is a fundamental condition for a genuine philosophical enquiry. While some respondents in the debate recognized the value of a conceptual basis for the practice of health visiting, a few questioned the wisdom of trying to establish "a body of theory" similar in character to the search for a theory of nursing, and considered it "an equally mistaken enterprise". I would maintain nonetheless, that the involvement of practitioners, teachers and managers of health visiting in this endeavour to examine the conceptual foundations of the practice of health visiting is unique in this country and has not been achieved by any other group which considers itself to be part of, or closely allied to the nursing profession.

11 Other concepts which nurse theorists consider important to relate in a conceptual framework of nursing care include, for example, health, man, perception, interpersonal relation,

action, process, social system, organisation, patiency, and self-care.

12 Two helpful expositions on the nature of models are those by Wartofsky (1979) and Jacox (1974).

13 The view that nursing is a social exchange activity which extends Henderson's need-response model by the notion of reciprocity, is discussed in some detail by Chapman (1978).

14 The principle of reciprocy refers to the constant, mutual interaction and exchange between man and his environment; that of synchrony indicates the space-time dimensions of this interaction, while helicy incorporates the notion of continuing innovative change that occurs unidirectionally out of the mutual interaction between man and his environment. The principle of resonancy is more difficult to elucidate in a brief note since it is derived from a central notion of Rogers' theory which identifies an energy field that is electrical in nature and has a boundary continuous with the human field boundary. In the model of interaction between man and his environment, resonancy postulates that change in the pattern and organisation of these human and environmental fields is caused by waves which cannot be seen. Reading Rogers' own exposition may be marginally less confusing than my inadequate attempt at summarising these salient points. However, since my purpose is not a detailed analysis of a particular theory, but the attempt to exemplify various kinds of contributions to theory construction in nursing, I feel still justified in concluding that it is difficult to see how these principles might be derived from a conceptualization of nursing and how in turn, they might inform, guide and predict nursing action.

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PART THREE

THE SELLERS

How to find a manageable approach to letting philosophers explain their discipline; explanations offered by philosophers of the purposes of philosophy, of the nature of philosophical problems, of methods used in philosophical enquiries, of the contents of philosophy, and of the relationship of philosophy with other disciplines.

THE SELLERS

The proposal to examine how philosophers identify and explain the nature of their discipline is a daunting one to make, but I cannot think how else nurse researchers and nurse theorists might decide whether or not all or some philosophical enquiries may have any meaning or relevance in nursing.

Although I have for some time now thought about this question, I am not sure that I could even tentatively suggest an answer without a fairly methodical examination of how philosophers see the contributions which they make to the understanding of our world.

I have already acknowledged that it is impossible to talk about philosophy without some personal conception of what philosophy might be. Since I have talked at some length about various ways in which nurses appear to be utilizing 'philosophy', I could now propose to trace the development of my '*Weltbild*' of philosophy in an attempt to demonstrate by what criteria I have judged some claims to a philosophy in or for nursing to be valid, and others to be invalid. However, this approach seems problematic to me for a number of reasons.

Having been introduced to philosophical studies by the historical approach[1] still common at continental universities (and one not particularly favoured by some British philosophers), I must have followed quite unknowingly what seems to have been G.E. Moore's advice on being asked what philosophy might be. The

story is told that he would gesture towards his bookshelves in answer to this question and declare, "It is what all these are about." (Flew 1979)

Reading one's way through major philosophical works from Plato to Wittgenstein could well be a useful approach if also in certain circumstances an impossibly time consuming one.

However, to offer here a historical survey of the development of philosophical "ideas and argument from Plato to Sartre" as Flew (1971) does in an introduction to Western philosophy, is not only beyond my ability, but might also be less useful for my immediate purpose. Such a wide-ranging attempt might obscure rather than illuminate fundamental ideas which might serve as a *starting point* for me to consider their meaning and relevance to nursing.

One might further argue that what is worthwhile in philosophical enquiries has indeed survived a few millenia into our time, even though there are those who think that some surviving concerns of philosophy are invalid and should be excluded from the proper scope of the discipline. (Peters 1966, Whiteley 1969)

Another consideration might be the likelihood that few nurse theorists will start with a comprehensive historical survey of philosophical ideas. I feel reasonably certain that most will use what there is rather than question how it has come about. This does, and indeed must not exclude a critical examination of current philosophical concerns.

I must also remind myself that my argument is not concerned with a detailed critical review of specific philosophical propositions. This is a task which appears to me to become rather more pertinent after I can comprehend what sort of philosophical enterprises might be relevant in nursing. There is also a practical question which I feel must deflect me from a historical approach to the development of philosophical notions and arguments generally, or more particularly to the development of my own ideas.

This is the question where a nurse theorist who is interested in exploring this field might start.

There seem to me to be two possibilities (perhaps rather naively and simply expressed here): either the nurse theorist has a background of philosophical education, or she has not. In the former case, there may be a high chance (unless the person, over time, has had various mentors) that a particular 'school' of philosophy might have dominated that education and will now become the departure and mould for her work as a nurse theorist.

This possibility is not confined to nurses who have engaged in formal philosophical studies. It is equally apparent, for example, in the work of nurses who utilize their psychological or sociological studies in nursing.

I believe this to be inevitable to some extent as long as some nurses at least do not gather the courage to forego the status of the 'specialist' or 'expert' and are willing to acquire

a more general but undoubtedly less specific range of knowledge about other disciplines which are seen to be relevant to nursing. I am certain that this is a question where the distinction between '*Wissen*' and '*Bildung*' again is particularly pertinent.

A nurse who studies, for example, psychology to degree level, will internalize the particular approach that prevails in the institution where she receives her education in psychology. Unlike the graduate in psychology who persues research in that discipline and, although quite likely, propounds a particular psychological theory, but is exposed to the criticisms of other psychologists who operate from a different theoretical base, the nurse who has accepted a particular theoretical base for her graduate studies in psychology, but does not continue her work in that discipline, is not exposed to such intradisciplinary criticism.

In her possibly fairly uncritical application of a particular psychological theory to the identification, analysis and solution of nursing problems, any intradisciplinary criticism must come from nursing colleagues rather than from psychologists. The reluctance of nurse theorists to criticize each others theoretical approaches and constructs has already been mentioned.

Since alternatives to the chosen approach are rarely indicated by the author, and since hardly ever any reasons are given for the preferred stance, an informed criticism becomes difficult to achieve in any case.

This general problem, as I see it, is fairly apparent in the transatlantic literature concerned with philosophical approaches in nursing. (For examples see Stevens 1979, McFarlane 1980)

Another explanation of what I perceive to be a problem may well be that the writer has already reached a point of commitment as a knowledgeable student of and as an experienced practitioner in the discipline of philosophy. The problem for the nurse theorist who has a less extensive and less committed background in the study of philosophy, or none at all, is that she may find it difficult, if not impossible, to enter into the discussion at that level, or to even appreciate her colleague's work as *one* possible approach to the matter in hand.

In this case it is very likely that whatever sources may be available in the person's particular situation, may be used in a perfectly legitimate attempt to learn something about philosophical concerns.

Therefore her sources could include the work of highly specialized and highly committed philosophers or more general introductory texts written for specific groups of people. Their authors may be alive or dead, well or little known, representative of major approaches or not, lucid or obscure. None of these and other possible differences would necessarily make any source more or less useful than any other.

What seems to be important, however, is that the nurse researcher or the nurse theorist acquires a reasonably comprehensive knowledge of what philosophers do and why they do it.

An in-depth study of only one area of the discipline (for example, logic) or of only one approach (for example, linguistic analysis) would not lead to an appreciation of what else is possible, and of the appropriateness of the chosen source for the purposes of the nurse theorist, as compared with other possibilities.

It seems to me important (in philosophy as well as in nursing) that a conceptualization of the purposes and problems of a discipline should be derived from what its practitioners actually do, and say they do.

Only after some framework has been established which allows the identification and ordering of various items of knowledge about, in this instance, philosophy, can more specific 'evidence' be meaningfully utilized (such as a detailed study of the arguments of a particular moral philosopher).

Therefore I shall examine various explanations by philosophers of the

- *purposes* of philosophy
- *problems* of philosophy
- *methods* of philosophy

- *contents* of philosophy
- *relationships* of philosophy with other disciplines

I am not suggesting that a discussion of these various features of a particular discipline should aim at a clear separation between them, since this would not only be impossible to achieve, but it would also negate the essential interrelations between them. For example, the kind of problems which philosophers may claim as their own must influence the choice of method that is held to be appropriate in advancing a solution.

Nonetheless, I shall find it necessary to try and concentrate in the main on the particular aspect under discussion. Otherwise I would find it impossible to follow my own argument, and I would almost certainly get completely lost in many conflicting views.

In trying to elucidate the *purposes* of philosophy one discovers that philosophers appear to be fairly unanimous; and that is in respect to the claim that they are unique in the extent to which they disagree with one another as to what their subject is. (Whiteley 1969)

There are many writers who preface their thoughts about philosophy with a sometimes brief and sometimes more expansive comment on the generally prevailing uncertainty about the nature of philosophical enquiries and their purposes. (Jaspers 1951, Feibleman 1958, Hartnack 1962, Ryan 1970, Bird 1972)

However, they invariably proceed to discuss what, in their opinion, can be studied by philosophers, and is worth studying.

Although this lack of a 'concensus of experts' as to the method and main conclusions of philosophy is regretted by some as a severe defect which demonstrates that the study of philosophy is still in a "rudimentary condition" as compared with the sciences, and which defect should be remedied (Sidgwick 1902), other writers consider this lack of concensus to be the special strength of the discipline,

> "... because the philosopher is operating in areas where there are no settled procedures (in the sense that there are no agreed necessary and sufficient conditions which enable us to know what count (sic) as answers to the questions we are asking), so he is likely to turn up new ones. The apparent weakness of philosophising, that is, in fact its strength." (Goddard 1962)

Goddard sees the purposes of philosophical enquiries arising from "an unwillingness to take for granted what normally is taken for granted", a view which is expressed even more strongly by Horkheimer (1972) who describes "the real social function of philosophy ... in its criticism of what is prevalent."

It is clear that the acceptance of prevailing ideas from mere habit does not satisfy philosophers who are united in the belief that "all novelty has to break through a cluster of habits." (Nidditch 1970)

Goddard points to the likelihood that the philosopher will turn up new ways of looking at questions simply because of the uncertainty that surrounds any answer in the absence of immutable

criteria for its validity.

Nelson (1949), a rather neglected early 20th century German philosopher,[2] makes an important observation when he shows how the discovery of new truths in the sciences anticipated the development of the methods necessary for their verification. He says that

> "The history of the empirical sciences and mathematics is rich in instances of how the genius of great scientists manifests itself precisely in their bringing to light discoveries the truth of which they themselves are unable to verify ... The scientist's genius is guided by a feeling for truth which leads him further and more surely than the traditional application of methodic rules."

It is pertinent here to refer to Feyerabend's criticism of Kuhn's argument (1970). Kuhn holds that scientists during periods of 'normal science' work in a scientific tradition which is guided by a single paradigm only (that is, standards of enquiry as laid down by current authorities are accepted and dutifully maintained).

But Feyerabend argues that when one looks at what actually happens in scientific work, one finds that *some* scientists are *constantly* engaged in what is basically the "philosophic argument", while a great majority may well continue to attend to their "tiny puzzles". But even following Kuhn's account, it is not the latter activity that brings about "progress" but the activity of the theory proliferating (rule-breaking) minority and of those experimenters who attend to the problems of this minority and their strange predictions. This speculative nature of philosophical

concerns is compared by Feibleman (1958) to the work in

> "a theoretical laboratory (where philosophers) explore (and experiment with) the abstract possibilities, for speculation is a sort of looking ahead at what practice could be."

The purpose of this tendency of philosopher scientists as well as of philosophers generally to 'break the rules' laid down by authority as currently determining the standards of enquiry in philosophising as elsewhere is *the advancement of human knowledge*.

However, it is not only in 'breaking the rules' that philosophers claim to be contributing to the advancement of knowledge. By

> "the clarification of ideas, the analysis of concepts, the study of universals and even the search for definitions",

Ryle (1945) would suggest, philosophers attempt to find out *what the rules are* which govern our thinking, our perception of reality and, so Winch (1958) would argue, our actions in this world as we understand it.

There is considerable disagreement between philosophers as to whether philosophy *only* contributes to an understanding of the world by removing impediments to such an understanding "thrown up in the course of non-philosophical investigations" (Winch 1958), that is "the view that philosophy consists only in the elimination of nonsense" (Smart 1963), or whether it has concerns of its own.

(Feibleman 1958, Winch 1958, Körner 1969, Bird 1972)

But this disagreement does not invalidate the claim that philosophy has *at least* this purpose, although it may have others, to provide the tools for and to engage in activities aimed at a *clarification of meaning*, the provision of the informal logic of an enterprise and a "programme of rational reconstruction". (Ryle 1945, Bird 1972)

This idea that "philosophy is concerned ... with the rational reconstruction of our conceptual scheme" (Smart 1963) which Bird expresses as a "programme of rational reconstruction" appears to me to be a central one in elucidating the purposes of philosophical enquiries.

If one conceives "philosophy ... as an enquiry into the nature of man's knowledge of reality and into the difference which the possibility of such knowledge makes to human life" (Winch 1958), then "it is certain that the character of a civilization is greatly influenced by its general view of life and reality." (Ewing 1951)

Furthermore, if it is the philosopher's task to find out what the rules are by which we order our thoughts about reality, that is by clarifying the meaning of the concepts we have of our world, then

> "in discussing language philosophically we are in fact discussing *what counts as belonging to the world*. Our idea of what belongs to the realm of reality is given for us in the language that we use. ... The world *is* for us what is presented through these concepts. That is not

to say that our concepts may not change; but when they do, that means that our concept of the world has changed too." (Winch 1958)

As Ewing (1951) points out, the conceptual constructs arrived at by philosophers

> "have a very important indirect influence on the lives even of those who have never heard of the subject. For indirectly it filters down through sermons, literature, newspapers and oral tradition and *affects the whole general outlook on the world*." (the italics are mine)

In reminding us that the scientific outlook which governs much of our current views of the world is in itself a particular world-view which was brought into existence by philosophers enquiring into the nature of man's knowledge, Ewing also argues that we could make no use of scientific endeavours "without having a more or less coherent world-view."

While Ewing pays particular attention to the fact that some aspects of philosophy have a more obvious practical influence than others, he also suggests that it is a mistake to assume that apparently practically useless enquiries may not eventually have far reaching effects on our world outlook.

Why this might be so may perhaps be explained by Feibleman (1958) who points to an apparent paradox in that

> "abstract studies often make their greatest advances in those periods when they are supposed by their professional advocates to be utterly useless."

The reason for this may well be that

> "the kind of intense and prolonged preoccupation that progress in such fields requires is possible only on the assumption that their applications do not exist."

This seems to me to arise out of the fact that enquiries which are geared to the solution of quite obviously practical problems or which were even inspired by the existence of such problems, are under a certain degree of pressure to come up with some relevant answers or solutions.

It may well be that the need to produce results (and this might apply to philosophical enquiries as to any other form of investigation) tempts the acceptance of a most likely solution even if the foundations for it may not have been explored and secured to the greatest possible extent. The investigator of an abstract problem (that is one that appears to have little or no practical applicability) can devote a great deal of time to the rational-logical foundations which may underlie any possible solution; in fact, the development of a coherent and consistent theoretical construct may be his prime purpose and any 'problems' may be incidental or illustrative rather than central to his task.

Its very coherence and consistency may give such a construct great persuasive power regardless of the possibility which Smart (1963) and Ryle (1945) indicate, namely that the propositions on which it is based may be invalid.

This possibility that invalid, biased, or ill-conceived assumptions may underlie philosophical speculation as well as that it may be done badly, seems to lead Ewing (1951) to warn those who engage in philosophical speculations and who claim that these are not aimed at any practical consequences since the purposes of philosophical enquiries lie in the disinterested pursuit of truth, that

> "bad philosophy can have a bad influence on politics, good philosophy a good. We cannot in any case prevent politics being influenced by some philosophical conceptions, and therefore it is very desirable to devote careful attention to philosophy in order to see that the conceptions which do wield an influence are good rather than bad."

While Ewing wants philosophers to keep in mind that philosophy might influence people's view of the world, he does not see it to be an explicit purpose of philosophy to engage in a 'programme of rational reconstruction' in order to create a rational world view.

Although Nelson (1949) is the most explicit when he says that the *ultimate* purpose of philosophy is to create "a scientifically grounded conception of life", that is, a rational view of the world,[3] he is not alone in this view among contemporary philosophers.

Flew (1979) appears to go along with a more moderate case, such as made by Ewing, when he states clearly that

> "we do need to notice that many of the issues of philosophy as an intellectual discipline are in some ways relevant to philosophy as world outlook. ... If, for instance, either an analysis of the concept of knowledge or an examination of the presuppositions and implications of

> scientific practice should reveal that authentic objective knowledge is either generally or in some particular spheres impossible, then it must become preposterous to strive to subordinate private practice or public policy to what is thereby proved to be unattainable. Again, if the findings of the psychological and social sciences really show that there is no room for choice and for responsibility, then the rational man has somehow to jettison either these ideas or those of the human sciences."

If one considers as *one* argument what has been presented here in the words and thoughts of various philosophers who frequently exclude each others' main interests and concerns from their own way of doing philosophy, one would arrive at an not altogether incoherent sequence of purposes for which people might engage in philosophical enterprises.

What is taken for granted in the way in which we view our world, is questioned, analyzed, clarified and then, at least according to some philosophers, reconstructed into a more rational view of the world than prevailed before.

That this 'taking apart' and 'putting together' is likely to result in different conceptions of reality, of what we know and can know, is surely apparent in the development of philosophical ideas and arguments over time.

To accept Sidgwick's, and to some extent Jasper's views of philosophy as not having "progressed" (as compared to the empirical sciences) appears to me to beg the question. To compare the lack of concensus amongst philosophers with the apparently greater degree of concensus amongst empirical scientists is to compare quite different kinds of activities about which agreement might or

might not be reached.

To point to the apparent finality of answers arrived at in empirical investigations as compared to the presumed unanswerability of philosophical questions, again, is to compare quite different purposes which need not share (and do not share) the common characteristic that they include a striving for finality in settling the matter in hand.

If, as I suggest, the fundamental task of philosophy is one of *ordering* what we know about our world and of judging the claims to any such knowledge, then this task must be neverending as long as we believe that there are still new things to be known.

While the empirical sciences add to *what* we claim to know, the philosopher must continue to appraise the question of *how* we know and how we can know, and how we can order our knowledge in a coherent and consistent way.

A passage from Wittgenstein (1958a) seems to express precisely why the purposes of philosophy do not admit of either complete concensus or finality.

> "Imagine that we had to arrange the books of a library. When we begin the books lie higgledy-piggledy on the floor. Now there would be many ways of sorting them and putting them in their places. One would be to take the books one by one and put each on the shelf in its right place. On the other hand we might take up several books from the floor and put them in a row on a shelf, merely in order to indicate that these books ought to go together in this order. In the course of arranging the library this whole row of books will have to change its place. But it would be wrong to say that therefore putting them together on the shelf was no

> step towards the final result. In this case, in fact, it is pretty obvious that having put together books which belong together was a definite achievement, even though the whole row of them had to be shifted. But some of the greatest achievements in philosophy could only be compared with taking up some books which seemed to belong together, and putting them on different shelves; nothing more final about their positions than that they no longer lie side by side. The onlooker who doesn't know the difficulty of the task might well think in such a case that nothing at all had been achieved. - The difficulty in philosophy is to say no more than we know. E.g., to see that when we have put two books together in their right order we have not thereby put them in their final places."

Following this analogy (also cited by Flew 1971 in an argument concerning the possible progress in philosophy) one might compare the contributions of the empirical sciences with an addition of one, or a number of new books to the library. The philosopher's task is to judge whether they are worthwhile to be added to the collection (that is, whether their authors' claim to have produced worthwhile books is justified), and if she wishes to keep some order in the place, she might on occasions just put them into a vacant space, but on other occasions their addition might demand a new category to be created which may well mean a rather thorough reorganisation of the whole library.

In various ways, philosophers who see "philosophy as the attempt to acquire a synoptic view[4] of the world" by bringing "all intellectual disciplines into a harmonious relationship with one another" (Smart 1963) argue more or less on the lines proposed by Whiteley (1969).

Although philosophy contributes to our knowledge of the world by analysis and clarification, this is essentially a negative contribution since it simply removes impediments to our understanding. No philosopher, however, is really convinced that philosophy's contribution to understanding is entirely negative.

Whiteley cites James's account of philosophy "as an unusual attempt to think consistently ...", and not only within the context of a particular problem, but "over the whole range of our thought ...".

This involves having "a set of interpretative principles" which cover all the topics that we think about, and it involves having "an outline plan of the universe" in which everything can be assigned a place.

The quantative explanations of scientific fact cannot comprehend everything that exists and happens. There are vast problems of understanding and meaning which are not within the preview of any special science.

> "They are problems of synthesis, of how to combine the different sorts of things we believe about the world into a consistent pattern, how to heal the incipient schizophrenia which menaces a scientifically orientated civilisation."

Sidgwick (1902) and Jaspers (1951) are frequently criticized, mistakenly I think, for seeing philosophy as a kind of superscience *in the terms of the empirical sciences.*[5] Sidgwick explains the synoptic function of philosophy succinctly and elegantly -

> "The important distinction is that the Sciences concentrate attention on particular aspects of the knowable world, abstracting from the rest; while it is, in contrast, the essential characteristic of Philosophy that it aims at putting together the parts of knowledge thus attained into a systematic whole; so that all methods of attaining truth may be grasped as parts of one method, and all the conclusions attained may be presented, so far as possible, as harmonious and consistent."

It is not part of my argument to examine why at certain times and in certain places philosophers tend to emphasize the analytical function of philosophy over its synoptic purposes and vice versa. Nor would I wish to convey the impression that all philosophers take either one side or the other. For example, Ryle, Smart, Feibleman, and Körner all acknowledge both purposes as legitimate philosophical pursuits.

As a basis for the further discussion of the problems, methods and contents of philosophy and of its relations with other disciplines, I shall refer to the *purposes of philosophy* as

- criticism
- analysis
- experimentation
- clarification
- synthesis

Although I have already acknowledged the interrelations between the purposes, problems, methods, and contents of philosophy, and its relationship with other disciplines, it still appears reasonable to me to ask questions about philosophy which will

elicit, for example, the purposes of philosophers rather than their methods.

The purposes of philosophy emerge rather more clearly when I ask the question, '*why* do philosophers engage in philosophical activities or investigations?' than when I wonder, '*how* do philosophers set about doing whatever they say that they do?'. Possible answers to the latter question might tell me more about their methods than about their purposes. Likewise, it appears that asking '*what* is it with which philosophers are concerned.', might lead to some answers about the content of philosophy rather than about its purposes or methods.

But the 'what' of philosophy could also be described as *the problems which philosophers try to solve*.

I have evidently envisaged two sorts of answers to the question of what philosophers do, namely the problems which they try to solve and the content of their discipline. It appears to me that one might illuminate what philosophers do in much the same way in which one would endeavour to find out what, for example, 'scientists' do.

If I were to ask, 'what do scientists do?', it would not be unreasonable to be directed to, let us say, different departments in a university, where people called physicists, chemists or biologists conducted their work.

Similarly, philosophers describe their work in terms of subjects or areas like logic and metaphysics, epistemology and ethics, or even as we have seen, as theoretical and practical philosophy. All these areas of work in philosophy (as in the empirical sciences) undoubtedly convey something about the content of the discipline. However, what is clearly a division of labour, possibly based on diverse individual interests, among 'scientists' as well as among philosophers, or what might be a 'division' in terms of preferred theoretical approaches to the work in hand (for example, the various 'schools' of philosophy), is still seen to be part of a shared and common enterprise.

However, this shared and common enterprise is not easily identified by just summarising the content of the discipline as one might describe it in terms of its division of labour, interest, or theoretical approaches.

I would argue that what is common and shared lies in the *commonality of the problems to be solved or of the questions to be answered.*

Or to put it another way, the problems of philosophers are of a particular kind as are those of the 'scientists'.

The nature of the questions which interest a physicist is of the same kind as of those which occupy a chemist, although the former would show scant interest in proving or disproving the existence of a specific catalyst in a chemical reaction, while the latter might quite legitimately devote herself to this

specific question.

Similarly, the *nature* of the questions asked by a moral philosopher is the same as the *nature* of the questions that interest a metaphysician, although clearly, they are not concerned with the *same* questions.

I shall therefore distinguish the two kinds of answers that might emerge which relate to what it is philosophers do, by examining first the *nature of the problems or questions* which appear to be characteristic of philosophical endeavours, and only later will I attempt to show how philosophers organise their work by a division of subject areas, interests or theoretical approaches.

It is in the *organisation of the content* of philosophy that philosophers' *specific* problems or questions will become apparent.

A *philosophical problem* starts with a person wondering about what might seem to others a fairly obvious and settled state of affairs.

Let us assume that I am watching a train leaving the station. As it gets further away, it gets smaller and finally disappears. It is plainly false to say, 'the train is getting smaller', although this, and 'the train is gone', is just what we do say in everyday conversations about seeing someone off at a railway station.

But we know that the train, whereever it may now be, has certainly not changed in size nor has it ceased to exist. Nevertheless, I have seen something change in size and then disappear, and if it was not the train, then what was it? The answer seems obvious. What has changed is my visual image, or my perception. In saying this, I am making a distinction between two entities: the train and its visual image. These two entities, however, cannot be the same or cannot be identical, since one varied in size and even disappeared while the other one did neither. Does this mean that there are no ways in which we can say what this object, the train, is *really* like?

The size of an object is clearly independent of the observer. If this were not so, then the object would have a different size at one and the same time, if seen by two people simultaneously from different distances. This surely would be a contradiction and would negate our very concept of a thing or an object.

Since the train is *seen* at one time or at different times by someone whose perception is bound to differ from mine, how many different perceptions do I need to know about, or to experience myself, in order to be able to say what this object is really like? Why should I even imagine that I can infer the nature of an object by putting together various perceptions, be they my own or other people's? Can I rely on the corroborative evidence of others at all?

In other words, what is the relation between sensory perception and physical objects?

In pursuing this puzzle, one would undoubtedly get involved in the philosophical problems of appearance and reality, matter and mind, knowledge and belief, and countless others. (For example, see Russell 1967)

This illustration might demonstrate some general features common to all philosophical problems.

Firstly, that they arise from our experience of the world which makes us wonder at what we see and hear, say and do.

> "It is through wonder that men now begin and originally began to philosophize; wondering in the first place at obvious perplexities ..." (Aristotle 1956)

That philosophical problems are generated by perplexities about what we experience, is suggested by Goddard (1962) when he says,

> "... philosophical perplexity arises out of a declared ignorance; out of a willingness to admit that we do not understand what is going on here; or why we should accept this or that particular belief ...".

Even more explicit is Parker (1972) who sees the starting point of all philosophical enquiries in the knowledge which people pursue, claim and use in their everyday lives. The whole point of thinking about and investigating a philosophical problem is that the ideas it contains are related to what we are and what we want to do.

Secondly, that they cannot be solved by further observation or by further progress within the empirical sciences.

Whether I ally myself with philosophers who deny the independent existence of objects in the external world, or with those who argue the opposite does not change or affect the empirical data. In either care, I can only point to, touch, weigh, measure or in other empirical ways describe the same thing. Idealists and realists do not disagree about empirical data, and it would be useless to try and settle their disagreements by a closer inspection of the train, or by filming it in motion to show what it really looked like after it had left the station.

Their arguments are not empirical arguments but attempts to solve a conceptual problem.

It may, however, have become apparent that it is not merely a question of what one might call conceptual analysis. Although it might be useful on occasion, to identify and agree on the criteria by which we call an object a 'train', or by which we define an experience as 'perception', the object and the experience as such were not really the difficulties arising from my example. The possible answer does not lie in an agreement simply on what we *mean* but in "exploring all that makes such questions puzzling." (Russell 1967)

The problem at first may not appear to be a problem at all, or may seem to admit to a rather simple explanation. However, as Nelson (1949) points out,

"The philosophical problem is wrapped in obscurity. To be able to come to grips with it by finding clear-cut, searching questions demands many trials and much effort."

It seems that each question leads to another more general one until the specific problem has been submerged in a discussion of very general and universal features of our experience in this world. Any examination of philosophical writings will show the generality of the concepts with which philosophers concern themselves. Ewing (1951) among many others is representative in discussing such notions as induction and intuition, knowledge and belief, truth, matter and mind, space and time, cause, freedom, universals and God, as fundamental questions of philosophy.

This trend to generality is an important characteristic of a philosophical problem; therefore I will continue to characterize such problems by saying,

Thirdly, that they lead to or are conceptual problems of a particular generalized kind.

It may be important to note here that even those writers who do not see philosophy as having a subject matter of its own, point to its concern with general concepts common to the empirical sciences, among which number, cause, induction and deduction, probability, theory and proof are but a few. One might well argue that the attempt to explain and interpret the empirical sciences as one particular kind of enterprise in making the world intelligible to us, is either one of the major philosophical problems, or at least is a part of many philosophical problems.

Fourthly, that they are logical problems.

If philosophical problems arise from what appear to be absurdities and paradoxes, as the chosen illustration might indicate (for example, it is paradoxical to say that the train as an object can be of different sizes at the same time, or it is absurd to think that the train has literally disappeared from the face of the earth), then the problem is of a logical kind. That is not to say that it is necessarily a logical problem in the formal and classical sense of logic. It does not necessarily break the rules of formal logic, thereby yielding a contradiction. It is no contradiction to assert that the train does not exist independently of being seen by me or some other cogniscant being, but it may appear an absurd statement to make since we know that even when being locked up in a railway shed at times, the train is still there as an object which we know continues to exist.

It may well be that, what some people see as the progression to greater perplexity in following philosophical arguments which frequently increases one's sense of mystification, is in fact a clear demonstration of a question or assertion which appeared to be both meaningful and interesting at first, but on a close examination turns out to have been quite absurd. Perhaps this is what Wittgenstein (1958b) means when he says,

> "My aim is to teach you to pass from a piece of disguised nonsense to something that is patent nonsense."

However, Körner's warning (1969) should be kept in mind that

> "To philosophize is not to be perplexed by the unperplexing, to cultivate perplexity for perplexity's sake or, even worse, to adopt the pose of being eternally perplexed. Perplexity is often not only the beginning but also the end of serious thought. (But) It is not its aim."

Fifthly, that there is not one specific way of settling the problem.

Goddard (1962) suggests that

> "what makes a problem a philosophical question, is that there is no *settled* way of answering it."

This seems to be supported by Wittgenstein (1958b) who holds that "A philosophical problem has the form 'I don't know my way about'."

When compared with the empirical sciences or with mathematics, philosophy seems to lack a generally agreed method for deciding the acceptability of its results.

The acceptability of any proposed solution to a problem depends on its initial definition which indicates what sort of answers could be expected as possible solutions, and on the degree of precision of the requirements which the solution of a problem must fulfil.

As Körner (1966) explains more fully,

> "In both these respects philosophical problems vary greatly. At one extreme we find problems of logic which are defined in terms of requirements which are at least as widely accepted and at least as precisely formulated as is the case with problems of mathematics. At the other extreme we find philosophico-religious problems defined by requirements which are accepted only by comparatively small groups of thinkers and which admit of very much less clear-cut formulation. This accusation that philosophy is 'subjective' in the sense of lacking a general agreed method for deciding the acceptability of its results tends to lose force as we move from the problems of *Weltanschauung* towards problems of logic."

However, it seems to me that a possible disagreement over the way in which a problem ought to be settled is not entirely unique to philosophical problems, especially if one compares them, as is often done, with the problems of the empirical sciences generally.

The precision of the requirements which an acceptable solution must fulfil varies considerably between, for example, physics or chemistry and anthropology or economics. Strictly speaking, it is only one feature of acceptable solutions which applies across the various empirical sciences, and that is that answers must be based on or derived from empirical data. (This, of course, does not apply to mathematics which is often quite unjustifiably included under the heading of 'science'.)

If one would wish to argue that at least within one discipline of the empirical sciences, for example, chemistry, there is quite general concensus of the criteria by which an acceptable solution may be recognized, then again, this does not distinguish philosophical problems from other kinds. Taking logic as a

comparative example within the wider field of philosophy, some would argue that agreement as to what counts as an acceptable answer is high and based on very precise criteria.

Similarly, if one looks at some other discipline among the empirical sciences, for example, sociology, then it seems not so different really from the situation, let's say in epistemology, where there is greater diversity about what should count as a 'solution'.

Furthermore, just as all empirical sciences share one condition which prevails in relation to all potential solutions, namely their empirical basis, so one could argue that all sorts of philosophical problems share one condition, and that is that their possible solutions are solely based on or derived from *thought*. That which differentiates a philosophical problem from all other kinds of problem is "that it becomes clear to us *solely* through thinking." (Nelson 1949 - the italics are mine) It therefore seems pertinent to emphasize this feature as common to all philosophical problems, as

Sixthly, that they are only answerable through thinking.

If, as I have argued, philosophical problems arise from our experience of the world which makes us wonder at what we see and hear, say and do, then it seems that philosophical thought needs to be purposeful.

What is fundamental to all philosophical problems is that they raise questions regarding the nature and intelligibility of reality. (Winch 1958)

The investigation of the nature, causes and effects of particular real things and processes which can be observed in our world, is the primary aim of the empirical scientist. But what is 'real' involves more than what empirical research may show to be the case. The question expresses the problem of man's relation to the reality as represented by the results of empirical research.

Philosophical analysis of the problem reveals what it makes sense to say about the world.

It is not at all clear at the outset whether the scientific description of the vanishing train as a vast collection of electric charges in violent motion is any more 'real' or meaningful than Berkeley's assertion that matter is really nothing but a collection of ideas. (Russell 1967)

> "Many of the concepts underlying philosophical problems are concepts by which we conceive of, describe and talk about reality. The way we conceive of and understand reality depends upon the way we conceive of an understand relevant concepts. ...
>
> To the extent that the concepts underlying our understanding, our description and our talk about reality are misconceived or deficiently understood, to that extent is our understanding, our description and our talk about reality misconceived and deficiently understood." (Hartnack 1962)

The widely held misconceptions that, for example, 'science' starts with observation and that observation yields a *secure* basis

from which knowledge can be derived, have been rejected by many scientists (but perhaps mainly by philosophers of science like Chalmers 1976 and Nagel 1979). However, there continues an adherence to these doctrines which is evident in the still widespread endeavour to establish statistical laws based on observations of what happens, and to insist when a proffered interpretation is shown to be suspect in some way, that more or different quantitative measures and manipulations would increase the compatibility of an interpretation with the statistics. But

> "The compatibility of an interpretation with the statistics does not prove its validity." (Winch 1958)

The validity of an interpretation rests on

> "what place in the whole scheme of things is held by the realm of facts with which (science) deals or even how they are related to the human minds which observe them. ... The sciences presuppose certain concepts which are not themselves susceptible of investigation by scientific methods and therefore fall in the province of philosophy." (Ewing 1951)

It seems that I have returned in a way to the beginning of my attempt to elucidate some common features of philosophical problems. It may serve as a final distinguishing characteristic of philosophical problems to say,

Seventhly, that they are concerned with the nature of reality and its intelligibility.

"The number of philosophical problems is *legion*", suggests Hartnack (1962) and

> "If it is true that philosophical problems have their roots in an insufficient understanding of the nature (or, as it is also called, the logical structure) of our concepts, then it is also true that we cannot once and for all determine their nature."

It would seem foolish for me to think that the features which I suggest characterize a philosophical problem are only those which I identified or, indeed, that each one of them is only applicable to philosophical problems.

I have already pointed out that the lack of a generally agreed method for dealing with philosophical problems may not be quite as unique to philosophy as is often assumed. Similarly, one may object to the suggestion that the origin of philosophical problems in our experience and their concern with reality are unique features which readily distinguish philosophical from other kinds of problems.

But all the suggested features together - and some, I would maintain, are only applicable to philosophical problems - should provide an outline of the commonality of philosophical problems.

I shall therefore refer to the *problems of philosophy* as

- derived from and informed by experience
- insoluble by empirical investigations
- leading to particular generalized conceptions
- revealing logical paradoxes and absurdities

- not being settled in one specific way
- only answerable through thinking
- concerned with the nature and intelligibility of reality

Although philosophers emphasize frequently that philosophy is distinguished from other human enterprises which aim at an understanding of our world, by its *method or methods*, they are extremely reluctant to identify, explain and discuss methodological questions.

If I take 'method' as a planned way to set about some task, then philosophy must have such methods to achieve its purposes of criticism, analysis, experimentation, clarification, and synthesis.

The entry in a dictionary of philosophy which reads, "Methodology. See science." is illuminating. (Lacey 1976) We learn (on looking up 'science') that "the study of how science works, or should work ... is often called methodology ...". It is clearly seen as the philosopher's task to undertake such a study of the methods which are employed by scientists. The author continues,

> "When studying the nature of scientific reasoning we *naturally* ask how it can be justified, and what are its purposes. In what circumstances can a scientific statement be properly accepted? ... the main purpose of science is perhaps EXPLANATION, and an important part of philosophy of science concerns what this is and how it is achieved." (the italics are mine)

Why should it be 'natural' for philosophers to enquire into the ways in which science works but not to discuss the ways (or methods)

of philosophy?

It seems equally sensible to me to ask how philosophical reasoning can be justified and what its purposes are. In what circumstances can I properly accept a philosophical statement, and what sorts of explanations do philosophers offer, and how are they achieved?

The possible objection that philosophers are not in the business of giving explanations, I would not only consider to be invalid, but also irrelevant to the question why they are generally reluctant to discuss their methods. I believe it to be invalid in the sense that there are explanations of very different sorts. The philosopher does not set out to offer a scientific explanation (that is, to show why something had to happen) nor necessarily one which simply makes clear what something or some sequence of events is (although some 'what-is' explanations can certainly be found in philosophical writings). But he does endeavour to find what have been called 'reason-giving explanations'. (Taylor 1970)

From much of what has been said about the purposes and problems of philosophy, it must be clear that philosophers are concerned with explanations of meaning.

Taking the most general definition of an explanation as "The process of making something intelligible", (Lacey 1976) leads me to believe that, by the declared purposes of philosophy, philosophers are engaged in looking for explanations of some kind.

The question whether or not this is so, however, is not the same as asking whether or not they should endeavour to identify, explain and discuss their methods of enquiry.

One often cited reason for not attempting such an explanation is the essential need for participation in the philosophical enquiry. Nelson (1949) argues, rightly, I believe, that

> "Philosophical truth is rather of a special sort. It is not a matter of knowledge but of insight. One masters it not by erudition but by *thinking it through for oneself*." (the italics are mine)

Brand Blanshard writes in the foreword to the selected essays that Nelson believed that

> "the business of philosophy was criticism, the bringing to light of the fundamental presuppositions of our thinking, the ultimate standards - logical, ethical, esthetic - that are implicit in our ordinary judgments. Nobody can tell us from the outside what these presuppositions are, since nobody but ourselves can know what we really think; we must see these things for ourselves; we must arrive at them through a process of self-examination and self-criticism."

However justified this demand for participation is (I have emphasized its importance and have attempted to substantiate it in the course of my argument), it is not a sufficient reason for not explaining something about the methods which are appropriate in a philosophical argument.

On the contrary, it may be even more important to explicate the meaning and significance of various ways of setting about thinking philosophically than it may be to offer an exposition of

scientific methods of investigation to students of the empirical sciences (without denying that they might benefit from such an attempt).

> "... method enjoys in these sciences a recognition so unchallenged and matter of course that students following its guidance are often hardly conscious of the assured course of their researches.",

observes Nelson (1949). As long as the results are compatible with the declared expectations in their respective disciplines, students of the empirical sciences do not need to question closely the methods by which these are obtained.

But as has been said often by now, the results, if any, of a philosophical argument do not necessarily justify its reasoning.

> "... whatever the argument or explanation with which we are presented, there are always two different kinds of questions which we can sensibly ask about it; the first concerns the logical structure of the argument and relates to its internal validity, the second concerns the factual truth ... and relates to its external relationship with the facts." (Ryan 1970)

It would only appear reasonable to point out from time to time, by what criteria a person could judge the validity of a philosophical argument, and since by definition, she must *engage* in it, what options may be open to her to pursue this kind of argument.

What I am really saying is that I am not convinced that the methods of philosophy are self-evident and would become clear

just by participating in philosophical arguments. It may well be that some 'bad' philosophy is offered by people who have not discovered by 'doing it' that "without the guidance of method" their speculations constitute nothing more than "merely a leap in the dark" and will leave them where they were before, "prey to the arbitrary." (Nelson 1949)

What might be a more legitimate reason for the reluctance of philosophers to engage in discussions of method, is advanced by Bernard Williams in an introduction to some philosophical essays by Isaiah Berlin (1978).

The main medium of philosophy is conversation (a point which I emphasized in the introduction to my argument).

> "The translation from dialectic to document is ... something that many philosophers of many schools have found problematical."

There is little denying "that something essential to the subject itself (is) lost in the transition to print." There is also a second transition that has to be made, and that is from the person engaged in a philosophical argument to the person represented in print. Williams sees that transition as resulting in losses "which are clear and determinate, even if they are hard to describe." Each person conveys in a face-to-face argument

> "that no abstract or analytical point exists out of all connection with historical, personal, thought: that every thought belongs, not just somewhere, but to someone, and is at home in a context of other thoughts, a context which is not purely formally prescribed."

However, there are limitations of opportunity and of time which do necessitate a less than perfect concern with certain issues. They must lead to compromises and a conscious setting of limits of what one might achieve. In this sense I see as the sole object of my attempt here, to identify some of the methods which philosophers use in their enquiries, to elicit some of their distinctive features, to direct attention to their variety, and thereby to promote an appreciations of them rather than offering them as 'recipes' (a particularly inimical thought to any philosopher) on how to proceed.

The most common description of philosophical methods is one of enumeration, such as Nidditch (1970) offers in a discussion of intellectual virtues.

> "The intellect and its virtues are relevant to all affairs involving, especially, inference, criticism, classification, the entertainment of alternative possibilities, understanding, conceptual knowledge, and coherent communication. ...
>
> The history of thought is the successive adoption and disclosure of error and the replacement of one set of explanations by another."

Although Nidditch does not really explain what he means by intellectual virtues, it is clear from the argument that they assist us in the "effective organisation of thought". In showing us what it is that needs to be organized, he points to some of the things which we do when we are thinking (for example, inferring, criticizing, classifying, entertaining alternative possibilities) and to some of the possible and

desirable outcomes of our thought (for example, conceptual knowledge, coherent communication, understanding, explanations).

Even if we were to agree that what we are doing when we are thinking in particular ways, may lead us to some of the methods of philosophical enquiries, this kind of enumeration does not tell us much about what exactly is involved when we infer, classify or criticize.

Both Goddard (1962) and Smart (1963) refer to techniques and procedures which philosophers use, or should develop and apply, but like many other writers, they then proceed to discuss certain theories or principles without elaborating on the aforementioned techniques and procedures, although Smart does equate clear thinking with "philosophy as linguistic or conceptual analysis" and to think comprehensively with "philosophy as the rational reconstruction of language."

In subtitling his book "An introduction to some aims and methods in recent philosophy", Bird (1972) raises some expectations about possible methodological explanations, but as he soon asserts, "The aim here is rather to formulate satisfactorily some of the background principles which govern philosophical activity" than to examine more closely the ways in which philosophers set about their tasks (with one exception, in the discussion of scepticism).

There are some exceptions to this general reluctance of making methods of philosophical enquiry more explicit. However, there is considerable difficulty in discussing, for example, expositions of conceptual analysis (Wilson 1963, Emmet 1968, Körner 1969, Whiteley 1969) which vary from a close examination of the whole process to rather more specific considerations of exhibition- and replacement analysis, and of reportive and stipulative definitions, in the way in which they are presented by their authors.

It is even more unlikely that one could relate systematically and coherently the above mentioned methodological explanations of conceptual analysis to those ranging from an exposition of

- the Socratic method (Nelson 1949)
- systematic ambiguity and abstractions (Ryle 1945)
- analogies and other representations (Körner 1969, Wartofsky 1979)

to explanations of

- doubting and describing (Körner 1966, 1969)
- questioning and judging (Emmet 1968)
- defining (Robinson 1968)
- explaining (Taylor 1970)

and instructions in establishing

- logical relations generally (Hamblin 1967)
- logical structures of arguments in particular (Ryan 1970)

It does not appear useful to me to report in a random fashion what has been said by these various authors, quite apart from the difficulty which arises from the different styles and even lengths of the offered explanations. I can only endeavour to examine various aspects of philosophical methods of enquiry as they may become apparent in a much more general discussion.

If I take as my starting point the assertion that the problems of philosophy are essentially logical problems which are only answerable through thinking, then what might lead us to specific forms of thinking must lie in the nature of the philosophical argument.

The argument proper to philosophy should bring out the logical powers of the ideas under investigation by showing the precise forms of logical mishandling which would decrease their workability, that is, their usefulness for whatever task they were meant to fulfil in ordering our understanding of reality.

But we do not operate with single or solitary ideas. We express them in statements which suggests that ideas might have some logical power which can be diminished or increased by the connections made between them.

Reasoning involves passing from premisses to conclusions and so involves a relation and the things which it relates. It seems a necessary first step to examine by what methods philosophers might establish logical relationships generally,

and logical structures of arguments in particular.

It is not my intention to paraphrase a complete introduction to elementary logic, but to illustrate what *a method of establishing relations* generally might entail.

An important *logical* feature of statements is that the truth or falsity of one statement may depend on the truth or falsity of another. In particular, one statement may *imply* another, that is, knowing that the first is true may enable us to deduce that the second is true also.

In ordinary speech we often indicate a relation of implication between two statements by using words like 'therefore', 'so', 'consequently', or 'because'.

For one statement to imply another, it is not necessary that either statement be actually true, but it seems important to point out that *if* the first one is true (or can be shown in due course to be true), then the second statement must necessarily be true.

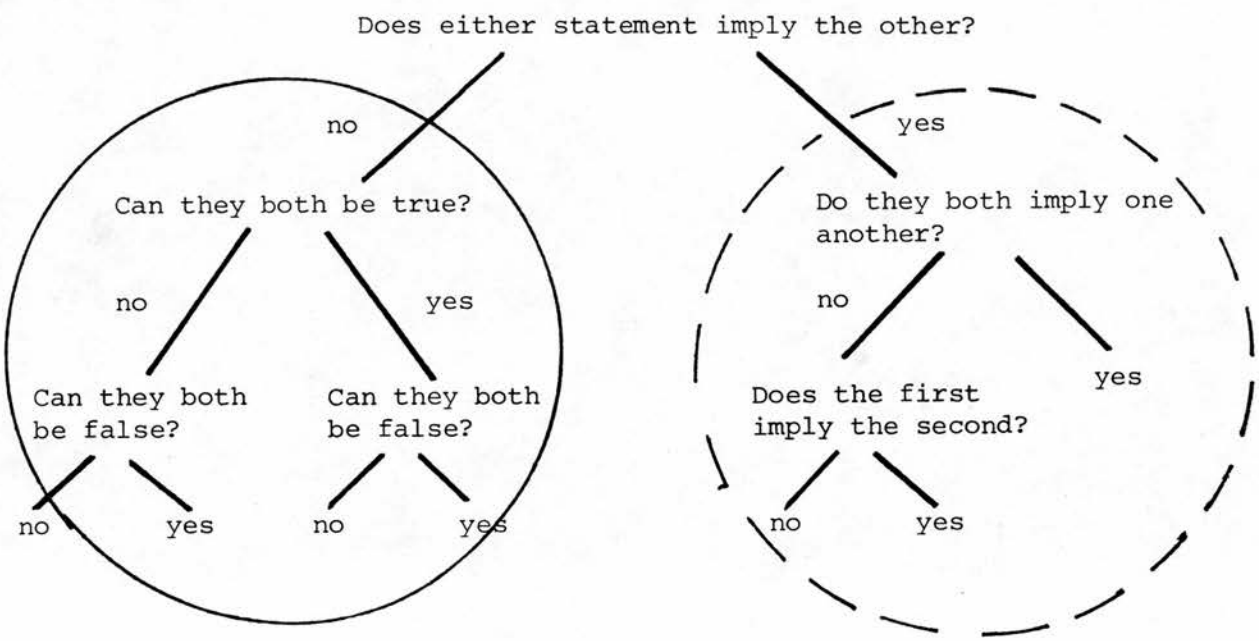
The statement, 'Jones is a male nurse' implies that 'Jones is male' and that 'Jones is a nurse". It must therefore necessarily imply that a nurse may be male, or that a male may be a nurse (these last two statements are equivalent).

Establishing logical relations includes among others the relations of contradiction or negation. The use of such words

as 'all' or 'none' invite logical contradictions, that is, they are often followed by statements which simply cannot be true at the same time as the first one which introduced the relevant idea.

'Nurse Smith is always punctual but today she is late' is a simple example of a contradiction since only one of these statements can be true.

How a logician may set about establishing logical relations generally is usefully illustrated with what Hamblin (1967) calls a "question-tree". In examining statements in an argument, he may ask:



While a descent towards the full circle would establish such logical relations as contradiction, contrariety, subcontrariety,

or indifference, a descent towards the broken circle would establish equivalence, superimplication, or subimplication.[6]

Another concern which must be met, if an argument is to be accepted as satisfactory, is the distinction between matters of logical validity and matters of factual truth. The central idea here is that the weakness in an argument may rest in either its logical structure or in the empirical data from which the ideas which are related, were derived.

If I made the simple but implausible suggestion that 'All nurses will get married', on the assumption that all nurses are women and that all women get married, I have offered a deductive and logically impeccable argument. A logician would set it out in the following form:

- all women get married (all A = B)
- all nurses are women (all C = A)
- all nurses will get married (all C = B)

The objection to my prediction is essentially factual, that is, what is challenged is not the validity of the internal logic, but the truth of the premisses. It appears clear that logical coherence on its own cannot establish the validity of my argument.

I may therefore decide to rewrite my example in accordance with the facts as we know them:

- some women get married (some A = B)
- some nurses are women (some C = A)
- some nurses will get married (some C = B)

It may well be that now all my statements in the argument are factually true, but it is now not a valid argument at all, since the conclusion, whether true or not, just does not follow from the premisses. Without demonstrating formally that this conclusion cannot logically yield a decisive prediction, one can appreciate that the 'some nurses' who are women, may not be identical with those 'some women' who get married.

This weakness is a matter of logic. I would have to set out to discover what other characteristics separated those who get married from those who do not, and how likely it might be that nurses will behave like other relevant reference groups. I may then be able to replace the logically inadequate premisses of the invalid argument with new ones from which a valid conclusion can be inferred.

Arguments, however, do not usually consist of such rather simple statements as I have offered above.

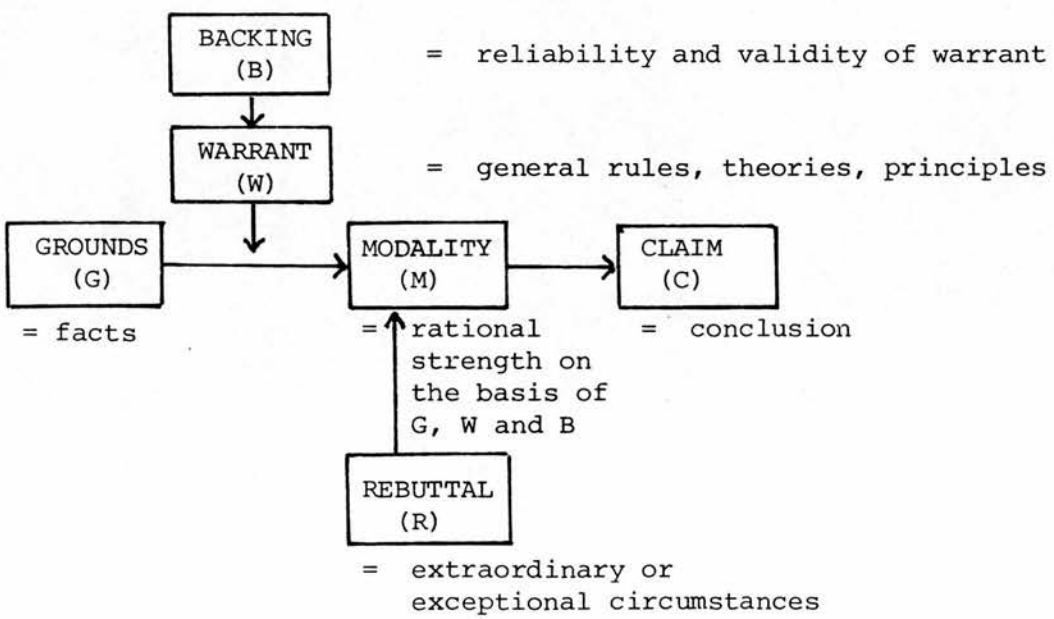
An argument consists of a whole sequence of interrelated claims and reasons. Although it may be useful to examine some key statements in a more formal way, the analysis of a whole argument seems to involve more than that.

Toulmin *et al* (1979) suggest that rational criticism of an argument must involve questions about its starting point and destination, about the procedures which it should follow, about what stages it might pass through and how these may be related, and about what questions must be asked, or what tests must be employed in checking whether it is fully reasoned through or not.

Each element of an argument - its claims, grounds, warrants, backing, modal qualifications, and possible rebuttals - must be critically examined.

Criticism as a method (that is, as a planned methodical activity to achieve one or more of the stated purposes of philosophy) is clearly illustrated by Toulmin.

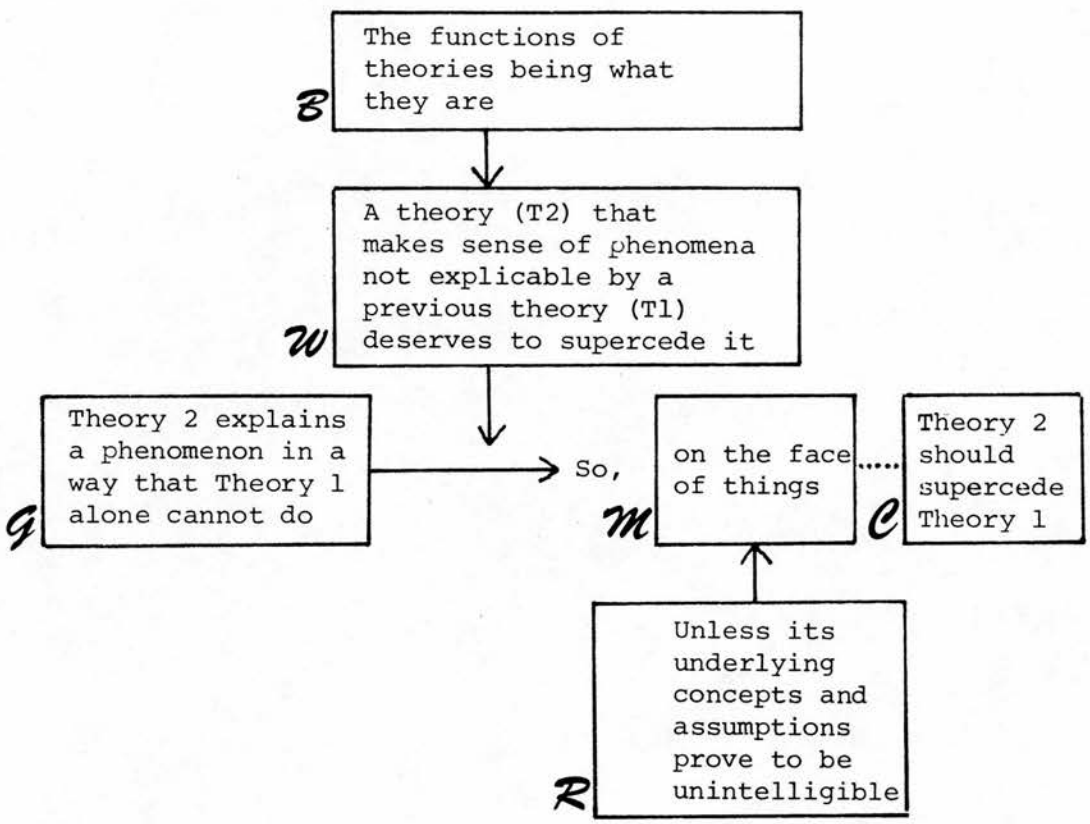
A diagrammatic representation which I have adapted without materially altering it, not only shows the interdependence of the various elements of an argument but it also indicates how criticism of an argument may have to proceed.



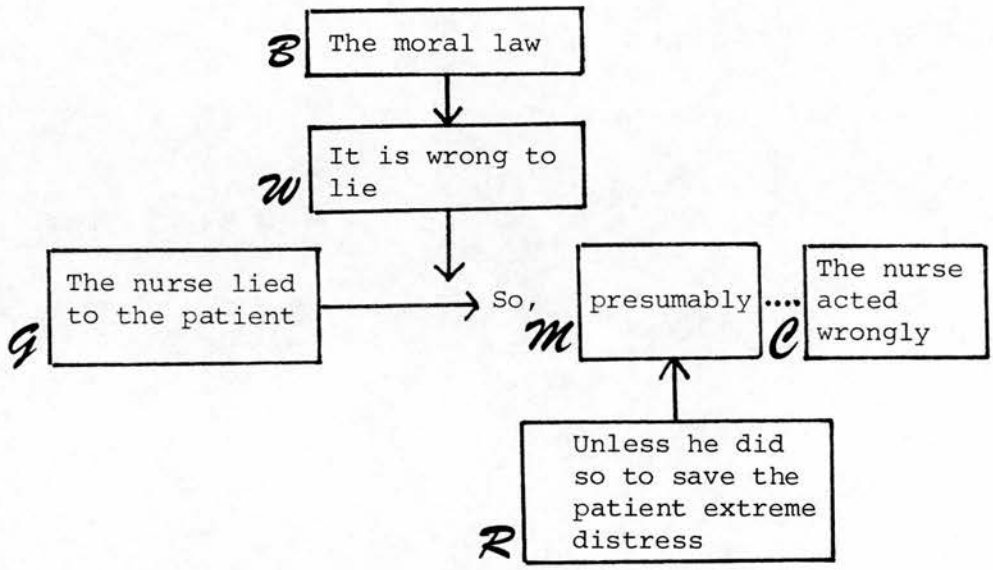
The authors show that a critical analysis, as a method of enquiry, can be applied to any argument from a fairly concrete case to a theoretical or mathematical proposition.

I shall offer two examples here, one theoretical and one fairly concrete case, to support this assertion.

First example:



Second example:



The criticism of this second argument might not centre so much on one or the other of its elements as such, but on the concepts contained in them.

Honesty, morality, and even distress are not indisputably established in such a way that the assertor of the claim *means* the same thing as those who refute it.

Even if not

> "all philosophizing is a battle against linguistic bewitchment, ... it is nevertheless inescapable that language must be the medium of all philosophizing, or at least of all ... that is communicated." (Emmet 1968)

Popper (1972) who is certainly pragmatic as far as method goes, protests strongly that "logical analysis" or "language analysis" should be thought to be the only method which a philosopher may use. But he does agree

"that something which may be called 'logical analysis' can play a role in this process of clarifying and scrutinizing our problems of our proposed solutions."

The techniques involved in analyzing concepts have been identified, demonstrated, and discussed by Wilson (1963). From isolating questions of concept (as opposed to questions of fact and of value) to establishing a shared and acceptable meaning, model cases, contrary cases, related cases, borderline cases, and invented cases serve as models of the appropriate use of the concept and allow its pertinent features to be identified and to be clarified.

The aim of such an analysis is clearly

"to exhibit the meanings of expressions used by a group of speakers and thinkers.",

and more precisely, to accomplish

"the exhibition of accepted rules by reference to which the correct and incorrect uses of expressions are determined." (Körner 1969)

This type of analysis Körner calls 'exhibition-analysis' in which the rules governing a concept are made explicit, are agreed upon, and one 'meaning' of the concept is accepted, at least for the purpose in hand, as correct. The now better understood concept is then used in the proceedings.

But, Körner argues, philosophers quite frequently do something rather different. They do not just discern the meaning of a concept and then use it with perhaps greater clarity (although they

may do so on occasion), they *replace* one notion with another which does not suffer the apparent defects of the one it has replaced (for example, it is less self-contradictory, less vague or otherwise more suitable for the intended task).

Körner gives the example of Russell analyzing the notion of existence in terms of the notion of truth. Russell's analysis of existential propositions does not consist in discerning the meaning of the concept of 'existence' but in replacing it with the concept of 'truth'.

Körner explains that this is feasable as these two concepts have a certain relation to each other which justifies the replacement of one by the other when necessary.

The importance of making this distinction between exhibition- and replacement-analysis is that the latter must allow more than one possible answer and a whole range of criteria of 'defectiveness'. Far from settling the uncertainty which gave rise to the attempt at analysis in the first place, replacement-analysis formulates new conceptual relationships and may at first introduce more, rather than less complexity into the argument.

However, it should not be too difficult to appreciate that a rather intractable exhibition-analysis may point to the need for a replacement-analysis which might release the participants from an irredeemably defective concept.

Whiteley (1969) describes the outcome of a conceptual analysis of the exhibition type as a 'stipulative definition' which, he avers, "can only be done effectively in any given field of discourse by those who are expert in that field."

He sees 'reportive definitions' as attempts to show how a given word is used by a speech community, and declares this to be the task of the lexicographer.

This distinction between 'stipulative' and 'reportive' definitions which Whiteley indicates, appears, in his way of explaining it, to be a slight one.

I do not agree with Whiteley's apparently minimal distinction for two main reasons.

Although conceptual analysis occasionally examines by way of illustration how a word is being used in a particular speech community (for example, by native English speakers), it goes far beyond simply *reporting* this fact in the form of a dictionary definition (which in a rather invidious fashion often provides the greatest obstacle to *conceptual* clarity). But furthermore, Whiteley does ignore the fundamental importance that *defining* plays in philosophical enquiries (but not in the narrow sense in which it is presented by him).

One might argue that definitions are not only central to the concerns of formal logic (not to mention that part of it which deals with the theory of definition), but are also found in a great variety of forms in almost all philosophical writings

(notwithstanding the claim by some philosophers that a defined term fails to grasp reality).

Part of a list of names for the sorts of definitions offered by philosophers may read something like

- real definition
- nominal definition
- extensive definition
- ostensive definition
- analytic definition
- synthetic definition
- equational definition
- descriptive definition
- operational definition
- genetic definition

(Robinson 1968)[7]

To distinguish between the purposes and the methods of definitions seems essential, if one wishes to avoid perhaps elementary errors which may cause a great deal of unnecessary confusion.

I often wonder whether teachers realize that students, in fulfilment of the demand to 'define X', might do this by the method of ostensive rather than by denotative definition (that is, they may point to or otherwise physically indicate the object X, rather than verbally describe its characteristic features).

If this distinction were applied to nursing, one might propose some argument in favour of demanding evidence that the student is capable of ostensive definitions instead, or at least as well, of as of denotative ones.

Similarly, persuasive definitions serve rather different purposes than, for example, genetic or causal definitions. However, the former are not always recognized as devices to serve the adoption and recommendation of certain ideals, since they frequently use words like 'true' or 'real'. 'A real man never shows fear', is as persuasive a definition as 'Real butter is made from milk' is a causal one. So far, scant attention has been paid to the processes involved in defining objects, people, places and actions, because it is such an everyday activity, it seems. Nonetheless, there are important implications for those purposes which philosophical enquiries are meant to achieve.

For anyone who engages in a philosophical argument, the question whether definitions should come at the beginning or at the end of their exposition is a crucial one (or whether, indeed, they can conduct a 'definition-free' enquiry). The decision to adopt one or the other course may influence how the whole argument will be conducted.

One method of enquiry consists in the gradual approach toward a possible definition (although it may not be achieved). The implication of the whole procedure which is called the Socratic

method seems to be that definitions cannot be dogmatically asserted at the beginning but must be sought for in a laborious procedure which takes a long time, and indeed, constitutes the work as such.

Nelson (1949), like many philosophers believes that there is a method of philosophizing that is something other than just following the rules of logical thinking. "Obedience to the laws of logic is an indispensable precondition of any science", he maintains, but

> "The function to be performed by the philosophical method is nothing other than making secure the contemplated regress to principles, for without the guidance of method, such regress would be merely a leap in the dark, and would leave us where we were before - prey to the arbitrary."

The Socratic method, as a regressive method of abstraction, aims at disclosing philosophical principles by utilizing reflection to transform into clear concepts something which we already possess and which makes itself obscurely heard in every individual judgment.

A close scrutiny of any Platonic dialogue (at least in the part where it most clearly retains the conversational dialectic) reveals pertinent aspects of the Socratic method.

By paying a compliment and introducing a topic of interest and immediate relevance to the other person, the philosopher ensures not only the essential participation in the conversation,

but, as we might say now, establishes a necessary rapport which will allow her to take up a specific point from what the other person says, and use it for her own purpose.

This immediate purpose is to lead the other person to admit his ignorance so that the enquiry can be pursued. But to cut through the roots of other people's dogmatism, as Nelson puts it, creates anxieties and defences which could quickly bring the enquiry to an end.

It becomes perfectly clear that the Socratic method is a form of intellectual and emotional manipulation which can and does incite passionate responses.

When Nelson talks of the "art of forcing minds to *freedom*" as the first secret of the Socratic method, he clearly indicates that this force may well be resisted.

However, having admitted to this "higher level of ignorance", the other person may well be eager to proceed to a discussion of complex abstractions. This is to be resisted by the philosopher who in using the Socratic method must insist that first of all, observable facts of everyday life, taken from the other person's own experience, be examined.[8] By formulating a principle implied in the example offered by the other person and using it as a question, one may be able to proceed from judgments of which one is sure to those of which one is less sure. In this process of separating the particulars of individual experience from more general principles, the attention is directed to the

generalized characteristics of concepts as we grasp them, and to making them explicit by defining them.

It is usually said that the Socratic method utilises inductive thinking to the exclusion of deductive reasoning. This is only partly true as any closer examination of the Platonic dialogues will show.

What is true is that the participants in the dialogue frequently succumb to a danger that is inherent in the nature of an exacting enterprise, and it is this: having become involved in its mounting difficulties and unexpected distractions, they will begin to think of ways of modifying the method to make it easier. This tendency, springing as it does, from purely subjective discomfort, is likely to distort and even completely frustrate the enquiry.

In the course of the conversation, Socrates (as depicted by Plato) proceeds by not only forcing judgments on the examples offered by the other person, he also gives examples of his own which serve as model cases, contrary cases, related cases, borderline cases and invented cases in order to illuminate the appropriate or inappropriate use of the concept under discussion.

He deals with specifically cited authorities (that is, with the warrants and backing of the argument), and questions their competence. He asks for elaboration to explore logical inconsistencies in the argument.

As a method of enquiry, the Socratic method merges into, and utilises other ways of rational exposition. But it has distinctive features which make it immediately recognisable in whatever context it is employed.

Its distinctiveness lies in being dialectic and in being grounded in the particulars of individual experience.

One aspect which may indeed dishearten the participants in an enquiry, is the deliberate use of systematic ambiguity. It quickly becomes apparent in any dialectical discourse that one word can have two or more different meanings. One expression can denote an infinite variety of ideas. In examining these ambiguities, one may discover the commonality of these ideas but one also finds that the existence of unnoticed systematic ambiguities is a common source of confusion and problems leading to what Ryle (1945) calls "logical disasters".

It would therefore appear somewhat perverse to introduce deliberate ambiguities into a discourse at points where none seem to exist.

But there are at least two good reasons for operating with such a double-edged tool.

One is the discovery of what Ryle calls "the absurdities" which result from ignoring the different "logical powers" that one and the same word may possess in different senses, and which makes an impact upon us and shows that the differences should be

determined by pressing the search for further absurdities.

Another good reason is the capacity of words or phrases

> "to acquire new inflections of logical forces (which) is one of the chief factors making original thought possible. *A new thought cannot find a new vehicle* ready made for it, *nor can the discrimination of the logical powers of new ideas precede the birth of the knowledge* (by wont) *of how to think with them.*" (Ryle 1945)

Ryle would maintain that new concepts arise from existing ones; are, for a time, expressed by words which denote the old concepts; cause, in this "subversive role", contradictions and ambiguities; cause the old concepts to be examined; and may then be expressed in new words.

From asserting that problems of philosophy are essentially logical problems and that any method of philosophical enquiry should bring out the logical powers of current ideas under investigation, I have now reached a point where I have contemplated how we might discover the logical powers of new ideas.

It seems that in a sense I have come back to the beginning of my attempt to identify *some* of the methods which philosophers use in their enquiries, to elicit *some* of their distinctive features and to direct attention to their variety.

Whether one considers philosophy to have one method including various techniques or procedures or whether one considers these various techniques and procedures to constitute different methods, is not, I think, an issue which practically has any particular

import. I will therefore not argue with Popper (1972) who says,

> "The method I have in mind is that of stating one's problem clearly and examining its various proposed solutions critically."

It seems justified to me to claim that the *methods of philosophy* as illustrated by

- examining the logical power of ideas
- establishing logical relations
- distinguishing between logical validity and matters of factual truth
- criticizing an argument
- analysing concepts
- examining definitions
- employing the Socratic method
- utilising systematic ambiguity in the creation of new thought

must assist in stating philosophical problems clearly and in critically judging their proposed solutions.

The kind of problems that philosophers make their own and with which they deal in particular ways are common to all branches of philosophy, or of what one might call the technical divisions of philosophy as an academic discipline.

The *content* of these special areas of philosophical enquiries is variously described, but the following outline would be reasonably representative of such descriptions.

It is customary to order philosophical content into the more predominantly theoretical, practical and applied areas of work, although these distinctions are by no means absolute.[9]

Logic, metaphysics, epistemology, ethics, aesthetics, and theology[10] could be said to be concerned with the most general philosophical problems of our reasoning about, and understanding of the world, and of our place in and relationship with it.

The central topic of *logic* is valid reasoning, its systematization and the study of notions relevant to it. In a broader sense, logic could be described as the study of the structure and principles of reasoning, and of sound argument.

There are recognized subdivisions, such as the study of formal logic, of logical theory, of the structure of arguments, and of ordinary language.

Those aspects which lend weight to a strong argument, and the consistency, coherence and accuracy of ordinary language are sometimes referred to as informal logic. The main task of formal logic is the study of the principles of deductive inference, or of methods of proof or demonstration.

A topic related to formal logic is set theory, and this, together with the study of proofs, leans heavily towards mathematical logic, and towards a philosophy of mathematics. Modern formal logic and mathematical logic are very close and are often referred to as symbolic logic because of their intensive

use of symbols in place of verbal expressions.

Logical theory examines the concepts involved in formal logic, and asks questions about reasoning generally. For example, is all reasoning deductive; are there different kinds of reasoning; what relations exist between premisses and conclusions; to what an extent can form and content of statements be separated?

The study of the structure of arguments and of other important areas such as definitions and explanations, brings logic close to epistemology on one hand (for example, in examining the notion of 'truth'), and to the philosophy of language on the other hand.

The interest of philosophers in the study of ordinary, that is, non-technical language is not as new as some authors claim. (Bird 1972)

One could argue that the Platonic dialogues where they most clearly demonstrate the Socratic method, evince a very searching kind of concern with the language people use to express their thoughts. Perhaps in some way, if not altogether, the "revolution" in twentieth century philosophy which discovered an "interest in ordinary language as a new topic for investigation" was at least partly a rediscovery and only in some areas "a distinct change from the traditional topics of philosophy."

Be that as it may, there is little doubt that there are many assertions by which philosophers appear to deny common-sense

beliefs. For example, they may claim that external objects which we believe do exist, do not exist, or that space and time which we seem to experience in a very real way, are not real at all. An appeal to ordinary language in certain circumstances seems justified and, indeed, rational, although its potential strength as testimony for or against a particular claim ought to be ascertained very carefully. (Quine & Ullian 1970)

An appeal to ordinary language may not provide the final refutation of a philosophical position but it may help to clarify the complex nature of the doubt that attends it.

"Of all the branches of philosophy, none sounds more alarmingly abstract than *metaphysics*." (Popkin *et al* 1956) One could add that it is also the branch of philosophy which has been intermittently attacked as being a quite illegitimate field of study for the philosopher, since the only effective way of answering its questions about the nature of reality is by empirical investigations. Starting with Hume and Kant in the eighteenth century, the criticism that knowledge sought by the metaphysician is not attainable, has continued to the present day. Some have suggested that one ought to abandon its traditional investigations and transform metaphysics into categorial analysis, that is, into the study of the necessary conditions involved in knowing anything (in which case metaphysics would become almost synonymous with epistemology).

Nonetheless, problems of permanence and change, and of matter and form have not been entirely solved by either empirical investigations or categorial analysis.

Questions about the fundamental nature of mind and body, and how they may be related, have only been partially answered by physiologists and psychologists (and some 'answers' accepted as such are in fact not particularly well substantiated mind-body theories).

The problem of free will and determinism has been argued for centuries by a variety of disciplines, but does not seem to be any nearer to a completely satisfactory solution for that.

As any other branch of philosophy, metaphysics is concerned with general concepts, in this case with those by which we describe and order our reality (for example, thing, entity, object, individual, universal, particular, substance, event, process, state).

For much of its history, metaphysics has examined the problem of categories, that is, the seeking out of some fundamental distinctions among the things in the world and among our ways of thinking and talking about them.

A central element in metaphysics which has seen a fairly consistent revival in the nineteenth and twentieth century (especially in Western European philosophy outside the Anglo-Saxon domain), is its attempt to characterize existence or reality as a whole, instead of, as in the various empirical

sciences, as particular parts or aspects thereof. Some authors would call it in this sense, a metascience (as Sidgwick and Jaspers do but, it must again be emphasized that this is not the same as equalling philosophy with science).

There are obviously many areas where metaphysicians and epistemologists pursue very similar questions.

Epistemology as the study concerned with the nature and derivation of knowledge, its scope and the reliability of its claims, is also a metascientific enterprise in the sense that scientific knowledge is one of the possible forms of knowledge under scrutiny by epistemologists. (The scrutiny of *particular* sciences will be referred to later as, for example, the philosophy of science, the philosophy of social science and so on).

One of the most general questions raised in epistemology concerns the reliability of sense data. If there is an objective reality, how can we be certain of its features and characteristics? One of the major reasons for doubting whether human beings can possess 'certain' knowledge has been the question whether we ever need to be absolutely certain, or whether we can manage, at least for all practical purposes, with knowledge that has a high degree of probability. But the criteria which may tell us to what extent we might be able to rely on both our knowledge which is derived from experience, and on that which is derived from reasoning, need to be creditable and consistent. The general concepts of particular interest to the epistemologist include notions like belief, knowledge, understanding, reason, judgment, sensation, imagination, and supposition.

Belief and judgment, imagination and supposition can be expected to play a central part in what are sometimes called the "value studies" in the context of philosophy; that is, ethics, aesthetics, and theology. (Feibleman 1958)

Although the study of *ethics* in particular appears to have a more direct bearing on people's lives than other philosophical pursuits, it is like all philosophical endeavours an investigation into the fundamental principles and basic concepts that are or ought to be found in a given field of human thought and action. "Being a branch of philosophy it is a theoretical study", declares Flew (1979).

Among that which makes us human is the experience of moral conflict and moral disagreements.

The examination of moral concepts and principles, of the criteria by which we judge one action to be good and another one to be bad, has always been the concern of the moral philosopher. More recent interests have centred on the examination of the language of morals by analyzing the meaning of terms like good, bad, right, wrong, ought and so on, and by attempting to demonstrate that moral statements are of a fundamentally different kind than, for example, scientific statements, and that they may therefore have a logic of their own.

A moral theory based on the analysis of the language in which we express moral statements may hold such statements to

be true or false, and possibly reducible to some concepts of an empirical science (for example, psychology), or it might contend that moral judgments are neither true nor false, but express merely the feelings of those who make them.

It may be quite apparent that even the more recent developments in the study of ethics lead us back to a classical question of moral philosophy. Is there some absolute quality of goodness or are all moral criteria relative?

One may assume that 'modern ethics' are not necessarily regarded as an alternative to ethical arguments in the classical tradition but as a preparation for the further study of classical moral theories. If one becomes clearer about the meaning of crucial terms and statements which occur in moral theories, it may be possible that one is in a better position to argue their strengths and weaknesses.

As moral philosophy is concerned with examining the meaning of goodness, so *aesthetics* is concerned with the creation, values and experience of the beautiful.

The primary topic of aesthetics is the appreciation of art, and by what criteria we might decide that something is a work of art.

Discussions of beauty have always figured in classical philosophical arguments but were, in the past, more often linked with epistemological and moral questions.

Historians judge aesthetics to have become a more distinct branch of philosophy since Kant, in whose view aesthetic consciousness and judgment are unlike either cognitive or moral consciousness or judgements. (Flew 1979) Aesthetic judgments are made entirely subjectively, that is, only with reference to the person who is making the judgment; although they may command common assent by others, "in virtue of the common ground of our subjectivity." An analysis of such concepts as meaning, intention, representation, and illusion is predominant in the study of aesthetics, as is an examination of the central notion of a 'work of art'.

Although I have found no reference in British dictionaries of philosophy[11] to *theology* as a branch of philosophy, I feel justified to include the study of God, or of the holy as Feibleman (1958) calls it, at this theoretical level in my overview.

I know, of course, that in academic divisions theologians do not normally see themselves as part of a department of philosophy. The fact that most universities have separate faculties of philosophy (or arts) and of theology (or divinity) may suggest that their incumbents pursue rather different enterprises.

However, this is not to argue about the rationale of the organisation of institutions of learning, but to examine the legitimate concerns of philosophers.

Ewing (1951) introduces the last of the problems which he considers to be fundamental in philosophy with the words,

> "We have left to the last the *philosophical question* of most extreme importance, both *theoretically* and practically, namely that of *the existence of God.* By 'God' I shall understand ... a supreme mind regarded either as omnipotent or at least more powerful than anything else and supremely good and wise." (the italics are mind)

Although some might hold that this question, if accepted as part of the philosopher's concern, may be subsumed under the study of metaphysics along with problems of space, time, eternity, necessity, change and contingency (that is, with the study generally referred to as cosmology), it seems to me to be of a different kind.

Metaphysics pursues, whether successfully or not does not matter here, questions relating to the reality of our world. Where it borders on, or merges with, epistemology, it still asks about what and how we can know about the world and about our place in it.

The study of the origins of the universe, that is, cosmological arguments, still retain the metaphysical perspective. The issues contained in these questions centre around theories, doctrines and common-sense beliefs which demonstrate the problems that we have in making our world and our experiences in it intelligible; they constitute the subject matter of philosophical reflection and analysis as I have described it so far.

Should I be justified in claiming, as I have done, that philosophical problems arise from our experience of the world which makes us wonder at what we see and hear, do and say, then these experiences are all accessible to almost everybody. We have either had some relevant experiences or we can bring them about at will.

> "Experiences at first hand of simple mathematical operations marks the beginning of the systematic study of mathematical theories which in turn leads to philosophy of mathematics. Roads to the philosophy of science, the philosophy of action and value, of social life and of history also start from generally accessible first hand experiences." (Körner 1969)

Although reason may transcend experience (as in Kant's transcendentalism which asserts the dependence of the world of experience on the activities of reason), we can generally reason at will; that is, we can engage in an activity which, although different from other forms of experience, is something we can 'experience' directly by doing it.

The *direct* experience from which questions about the existence of God or of some supreme mind or being may lead us to philosophical reflection and analysis, is *not generally* accessible, and it is not accessible by an act of will, that is by *deciding* to have a religious experience. The formulation of arguments for the existence of God can therefore not arise necessarily out of perplexities caused by direct experience. Furthermore, however we may define our time and space bounded reality, reflections on the nature of a supreme, omnipotent,

supremely wise and good mind must contemplate a different kind of reality than that with which metaphysics and epistemology are concerned. The nature of religious knowledge *may* include elements of religious experience, but it *must* be based on a very distinct process of thinking (and possibly feeling) which we characterize by words like supernatural belief or faith. The crucial concerns of theology (that is, of the study of God) are both different to those of metaphysics generally, and of a philosophy of religion.

Theology in the sense used here must be concerned with an examination of the superrational in rational terms, by examining knowledge claims of beliefs, faith and experiences which are not shared at will among all human beings, and by asserting rational standards in relation to which such claims can be justified.

I have already commented that the distinction between predominantly theoretical and practical areas of philosophical investigations is not absolute, and in some areas of work it may be more difficult to sustain than in others (for example in ethics, aesthetics and theology).

Nonetheless, some areas of philosophical study are clearly more theoretical than others (that is, they do not set out to relate any understanding that they may gain directly or necessarily to any consequent actions), although I would still argue that all philosophical enquiries have the potential to

affect 'practical' matters with which people are concerned.

Other enquiries are in a much more direct way 'action-orientated'. Those concerned with the nature of the state and its correlates of law, obedience, duty, liberty, justice, freedom, authority, obligation and many others, not only serve our general understanding of what one might call political realities but in strengthening or weakening political theories, they have a far more immediate 'action potential' than, for example, a metaphysical discourse on the nature of reality.

Political philosophy is concerned with the kinds of questions I have just indicated; and with *social philosophy* it has marked out an area for itself as an academic discipline within philosophy.

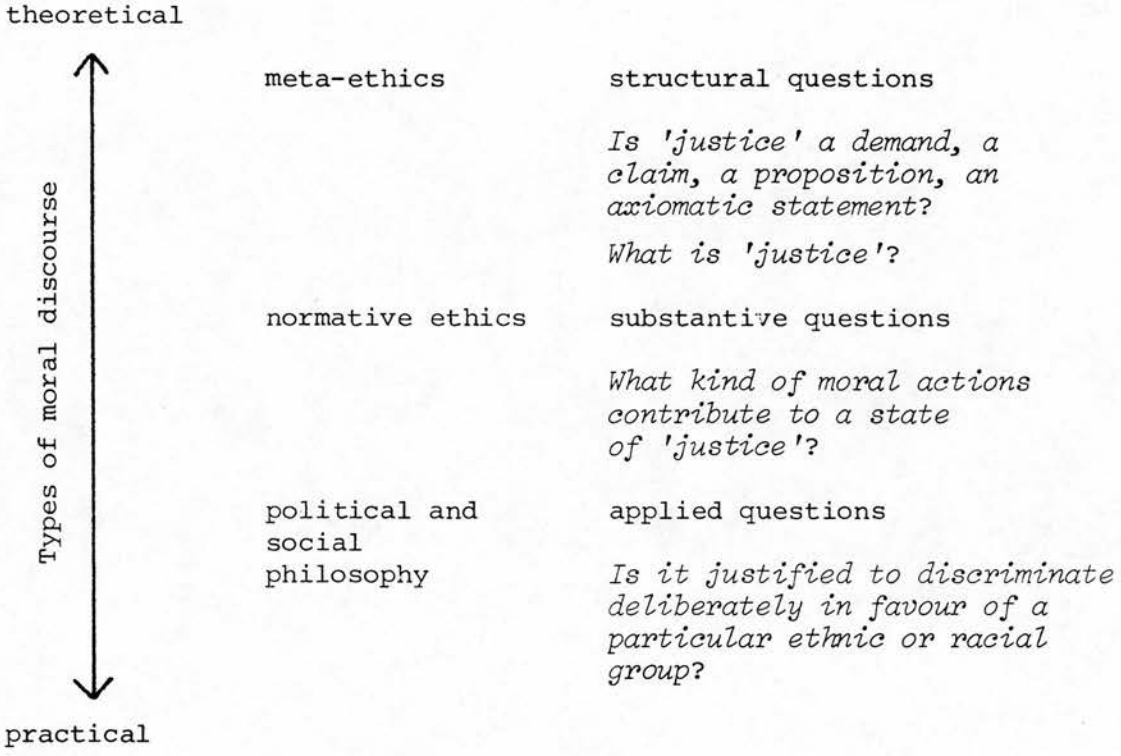
Flew's comment (1979) that it is difficult to distinguish clearly between political and social philosophy, and indeed, between these two areas and that of ethics generally, is justified. For example, the examination of the notions of individual rights and responsibilities is undoubtedly a proper concern for the moral philosopher who must analyze and reflect on such fundamental moral concepts as right, responsibility, duty, obligation, freedom and so on. Also, modern moral philosophers would claim that the language of morals is precisely that which is employed in socio-political discourse. Therefore one might assume that whatever we can learn about the way in which we use moral contentions, prescriptions, commands and claims, would tell

us also something about the way in which we talk about, for example, human rights.

But perhaps the political and social philosopher do ask questions more directly related to specific kinds of human action (that is, their field is more practically orientated), such as, "exactly who is responsible for war crimes?", or "must policies of 'affirmative action' and 'positive discrimination' in favour of members of formerly disadvantaged sexual or racial groups violate the rights of members of other sexual or racial groups, and be in themselves sexist or racist?" (Flew 1979)

I would find it invidious to prescribe at what point a group of people should be considered to be sufficiently distinct in their work, and therefore be nominally separated from others within their discipline. For the purposes of my argument, however, I find it more useful to think of political and social philosophy as part of the study of ethics, since it not only helps me to understand more clearly the often used distinction between theoretical and practical concerns in philosophy, but also because I can appreciate more easily that the *nature of the problems* has not changed and therefore makes the enterprise of political and social philosophers a *philosophical* one. An example might show how the content of a special area of philosophical enquiry corresponds to the possible distinction between theoretical and practical philosophy, and how its questions might be formulated in different types of discourse.

As I do not consider the distinction between theoretical and practical philosophy to be in any sense an absolute one, I shall indicate it as a *tendency* towards one or the other end of a range of types of discourse. Those tending towards the theoretical end can be considered less immediately 'action-orientated' but they still retain the potential to influence human action.



It should be noted that the questions in all types of moral discourse partake of those characteristics which identify them as indicators of philosophical problems; that is, they are derived from and informed by experience, insoluble by empirical investigations, particularly generalized in their conceptions,

not necessarily settled in one specific way, and only answerable through thinking. A closer examination would undoubtedly reveal logical paradoxes and absurdities especially in our common-sense thinking about them, and any possible solution would surely increase the intelligibility of that part of our reality from which the questions emerged in the first place.

It might be important to distinguish at the practical level between philosophical problems and, for example, operational problems.[12] Although what I have called an applied question (in, for example, political or social philosophy), refers to a much more *specific* problem than a question at the theoretical level, it is still concerned with establishing the criteria for a general principle of justice, and not with the solution of a specific operational dilemma (for example, should we discriminate in *all* employment policies in favour of women and black people, and if so, how?)

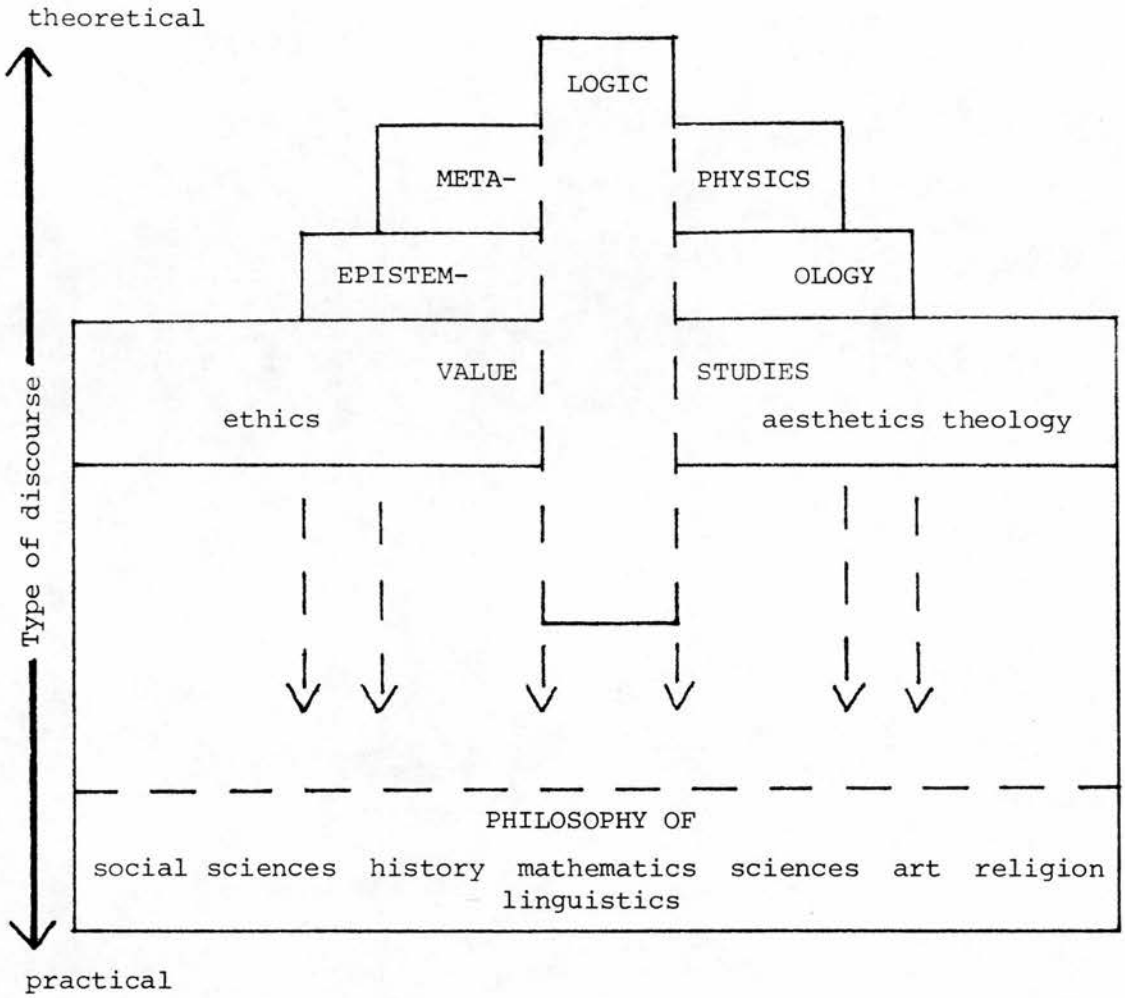
Far less, of course, are philosophical questions in whatever type of discourse, designed to describe instances of, for example, discrimination in employment or elsewhere. These are empirical questions which can only be answered by appropriate sociological or socio-political investigations. Any generalization derived from such empirical investigations might in itself become the object of further philosophical reflections but the empirical facts as we by then know them, would in no way be altered by any concerns of political or social philosophers.

I cannot see the various specialist areas of philosophy as entirely independent in any case, quite apart from any difficulty in clearly distinguishing theoretical from practical concerns.

It seems to me that, for example, epistemological arguments must inform, and must be informed by metaphysical, logical and moral enquiries, although undoubtedly to varying degrees depending on the focus of a particular argument.

The following attempt to summarize the overview of the *contents of philosophy* in a diagrammatic rather than in a purely verbal form should be considered as a representation of

- the central place of logic in philosophical enquiries
- the interrelatedness of logic, metaphysics, epistemology, and and value studies
- the tendency of various philosophical enterprises towards a theoretical or practical type of discourse
- the applied concerns of philosophy in relation to other disciplines *as a result of its own areas of enquiry*



By attempting to outline the content of special areas of philosophical investigations, the *relationship of philosophy with other disciplines* becomes apparent in some ways, as it has in other ways during earlier discussions in this argument. A particular relationship has already been indicated in the discussion of the concerns of metaphysics. Philosophy as a metascience endeavours to characterize existence or reality as a whole. In a synoptic view of the world, "philosophy must recognize the methods and results of the sciences" (Jaspers 1951),[13] but must transcend them by a rational discourse "to gain insight

into the essence of truth in its full scope under the present conditions of scientific knowledge and historical experience."

Sidgwick (1902) goes further towards an integrating function of philosophy by declaring an interest of philosophy in what ought to be as well as in what has been demonstrated by the empirical sciences to be the case.

He claims that

> "the aim of philosophy, in its widest sense, is to comprehend all rational human thought - whether it relates to 'what is' or to 'what ought to be' - as one coherent whole."

In relation to the empirical sciences, philosophy has developed another special relationship which is directed less at coordinating and integrating their separate results, but more at judging the appropriateness of the methods and canons of proof employed by them.

Sidgwick remarks with a great deal of justification which still holds today that particularly in disciplines where knowledge is growing fast in range or depth, there is continual conflict and controversy

> "as to the truth of new conclusions, which appear established and demonstrated to the adventurous minds that have worked them out; and as to the legitimacy of new hypotheses, or the validity of new methods; and wherever we find such conflict and controversy, there must be an error on one side or the other, or possibly both."

Furthermore, there are not only the controversies within particular sciences but also between different sciences. One science criticizing the validity of the methods employed by another and/or its particular conclusions is a phenomenon that has not vanished with Sidgwick's generation.

> "Such controversies force on anyone who aims at systematising the methods and conclusions of the sciences a searching inquiry into the fundamental assumptions of those methods."

Scientists, Sidgwick observes, are not particularly disturbed by the fact that certain scientific beliefs are found to be erroneous and are replaced by new ones. The scientist "on the whole, continues his usual processes of acquiring, evolving, systematising beliefs with undiminished confidence."

But for the philosopher who examines the general concepts, methods, criteria or proof, and processes of generalizations employed in the empirical sciences, and who deals with rational justifications for adopting criteria of acceptability of the results offered by the empirical sciences, the "special concern with the fundamental assumptions, as distinct from details, of a branch of study" would not appear to fall into the province of any other kind of investigation.

Consequently, these areas described as the philosophy of the social sciences, history, mathematics, linguistics, sciences, art and religion are concerned with questions about these disciplines as contrasted with questions within them. The questions of interest

to the philosopher, that is, those about a discipline, have been described as second-order or conceptual questions as they require

> "an account of the proper thing to say and think about the facts, or, ... an account of how we should conceive of them." (Ryan 1970)

A fairly representative approach to the philosophy of an empirical science would include questions and arguments relating to the nature of scientific theories, the logical character of scientific methodology, the criteria of acceptable proof, the problems of explanation, meaning and understanding inherent in the given enterprise, and to its place in relation to other empirical investigations.

The philosophy of non-experimental enquiries like mathematics, linguistics, art, religion, and history may raise questions about the nature of the sources from which the data for the practitioner of the discipline are derived, their nature and criteria by which their reliability and validity can be established, the nature of theory and other forms of representation employed in the field, the appropriateness of the methods chosen to advance knowledge in the field, and the criteria for reaching a concensus between the practitioners of the discipline.

It is not very surprising that the enquiries conducted by philosophers of science or history, for example, are sometimes seen to be less than useful by the practitioner of the respective discipline. As Ryan (1970) points out in this context,

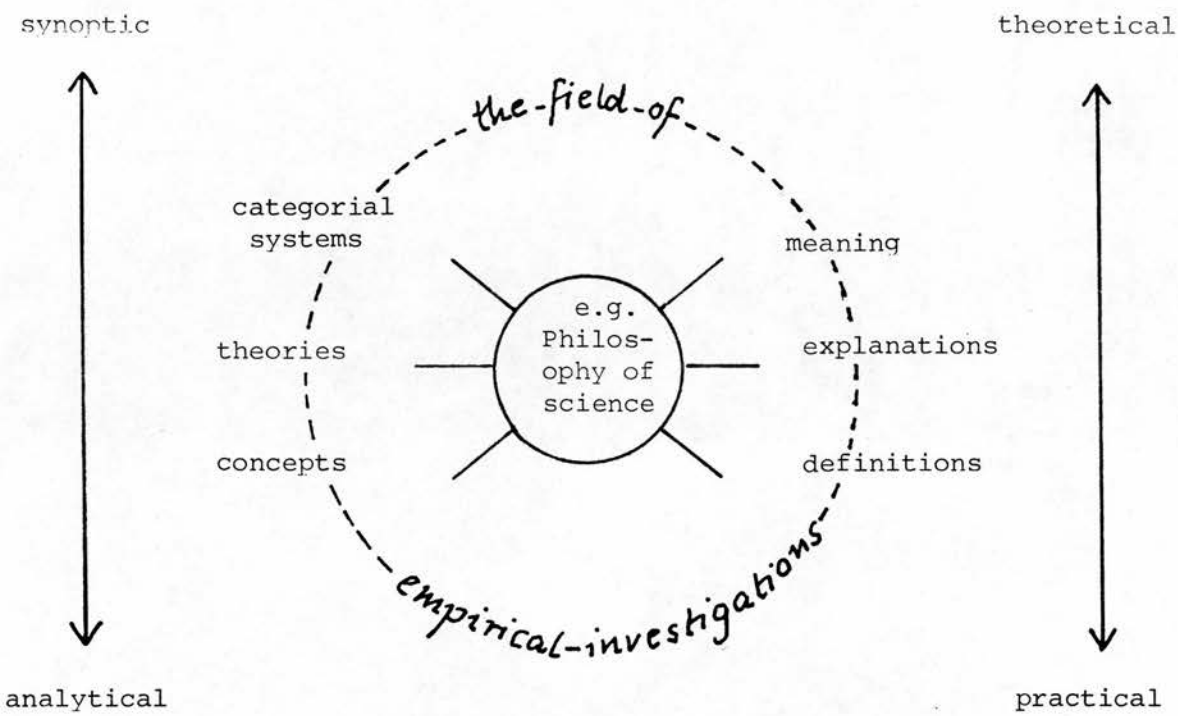
"philosophical questioning is positively dangerous
in that it distracts us from following the tried practices
of the intellectual, or moral and political community
to which we belong."

Less threatening on occasion, although not necessarily so, is the third kind of relationship that philosophy may establish with other disciplines by emphasizing its contribution to the clarification of fundamental concepts employed in the discipline, and to the informal logic which governs its discourses and arguments.

In a way, the relationship of philosophy with other disciplines could be seen to be fulfilling a range of functions from the analytical to the synoptic, and from the practical to the theoretical.

There appears to be a certain correspondence between the tendencies towards synoptic, theoretical concerns about the discipline and analytical, practical contributions to its endeavours.

A model of the relationship between these functions might have to incorporate further details than the ones I am about to offer here. But a model of this kind might suggest a possible starting point in identifying some fundamental aspects of how philosophical enquiries might relate to other disciplines.



From a necessarily limited survey of what philosophers say in describing their field, the purposes, problems, methods, contents and relationships of philosophy indicate a wide range of, and an almost infinite subject matter for, philosophical enquiries.

My earlier assertions that the way in which nurse theorists identify and handle 'philosophy' is not only particularly narrow and somewhat arbitrary, but also often misleading, is, I feel, substantiated by letting philosophers explain their discipline.

Not all philosophers would necessarily subscribe to the whole range of concerns which I have outlined here, and some 'schools'

of philosophy have adopted rather narrower aims. However, I feel that it would be a mistake for the nurse theorist who wishes to utilize philosophical methods of enquiry to adopt a singular approach or to accept particular philosophical stances before having examined critically alternate approaches and counterclaims of other 'schools'. Philosophers like other people tend to consolidate their respective stances and fall victim to habits, personal and institutional histories and preferences, and not least to intellectual 'fashions'.

Existentialism in Europe, dialectical materialism in the Marxist parts of the world, positivism in Great Britain, and value philosophy in the United States may all serve as examples of fashionable 'schools' of philosophy.

Feibleman (1958) describes each of these 'schools' as always having "all others as its opponents." He sees their adherents as disciplines imbued with an almost religious fervour which completely negates the tolerance, open-mindedness and self-criticism characteristic of all genuine philosophical enquiries. He may well be right that the most popular stances in philosophy are those advocated by "the largest and most successful institutions."

But philosophy as a "slave to other institutions" loses its whole raison d'être.

Philosophy ought to be an enterprise which leads

> "all those who suffer from philosophical opinion so confirmed that they would impose it as the absolute truth upon their neighbours, into the more passive channels of unsettled speculation."

However, some speculations are more relevant and potentially fruitful than others, and how one might determine the relevance of philosophical enquiries in nursing shall be the concern of the last part of this argument.

NOTES TO PART THREE

1 Here a necessary distinction should be made. The attempt to 'teach philosophy' by the description of chronological events and biographical data, even when philosophical arguments, set in their time and place, are part of this description, is rightly suspect. Nelson (1949) observes with justification that even "When expressed in words, these universal truths will be heard; but it does not necessarily follow that they will be comprehended." He continues, "It is accordingly impossible to communicate philosophy, the sum total of these philosophical principles, by instruction as we communicate historical facts or even geometrical theorems. The facts of history are not objects of insight; they can only be noted. ... But to present philosophy in this manner is to treat it as a science of facts that are to be accepted as such. The result is at best a mere history of philosophy.

However, a descriptive, chronological history of philosophy is not at all the same as a historical approach to the study of philosophy. Recently, Alan Montefiore could say, "that the tradition of philosophical study (in France) remains very closely related to an intense study of the history of the subject. ... Almost all French philosophers ... will insist that the problems with which they are trying to deal only emerge for them through their study of the work of those who have preceded them, and through ... the development of their thoughts ...". (Magee 1973)

There is a continuity in the development of philosophical thought which corresponds to, and is illuminated by, the social, moral and religious life of a people in a particular historical context. "Any study of philosophy that is worthwhile will lay strong emphasis on a knowledge of the historical development of philosophical thought ...". (Butler 1908)

2 Leonard Nelson (1882-1927) taught at the University of Göttingen for eighteen years from 1909-1927. His work includes Lectures on the Foundation of Ethics, and Lectures on the History of Metaphysics, as well as papers on general epistemological questions and on the methodology of science. He believed passionately that rational truth was not only attainable but essential in refuting the dominant philosophical schools in Germany during his lifetime (these started off as almost pure scepticism at the turn of the century and then merged with a strange brand of mysticism which rejected rational philosophical discourse in favour of an invented irrational 'truth'.)

3 When Nelson speaks of a 'scientifically' grounded conception of life, he does not refer to a conceptualization derived solely from empirical enquiries. On the contrary, he sees a need for clearly deductive rationally grounded propositions which are based on non-empirical enquiries. His demand for philosophy to become a 'science' (*Wissenschaft*) does not mean that he envisages philosophical investigations to be conducted in a manner similar to empirical ones. "Philosophical method ... is determined by the specific character of philosophical knowledge", he claims. Philosophy as a 'science' does mean that he wants philosophical methods made explicit (a task to which he devotes two essays). It also means that "Philosophical knowledge, like every sort of knowledge, becomes science only when the diverse cognitions that go to make up the particular knowledge are given the form of systematic unity." In other words, he wants to systematize philosophy so that the discovery and verification of its basic principles becomes possible. In that he sees the essence of a 'science'.

4 What the nature of such a synoptic view of the world might be, is explained by Sidgwick (1902) in greater detail. "I regard 'Philosophy' then ... as the study which 'takes all knowledge for its province'. To such a study the human mind would be palpably incompetent if it attempted to deal with all the facts: it therefore selects the most important. Thus if we conceive the sciences as sets of connected knowledge, and imagine them as rising from the particular to the general, we may consider these sets in their turn as connected by Philosophy at the higher end. Philosophy, therefore, deals not with the whole matter of any science, but with the most important of its special notions, its fundamental principles, its distinctive method, its main conclusions. Philosophy examines these with the view of coordinating them with the fundamental notions and principles, methods and conclusions of other sciences. It may be called in this sense *scientia scientarium*."

5 Jaspers (1951), like Sidgwick, is frequently criticized for claiming for philosophy the status of a superscience in the terms of the empirical sciences. Neither of them does any such thing. Jaspers feels that "Our sense of inadequacy of each special branch of knowledge demands that each science be connected with knowledge as a whole." Modern sciences need to be integrated into a universal frame of reference. What Jaspers finds missing in modern conceptions of science is a quest for meaning behind the truth searched for by scientists. He considers the preoccupation of the sciences with facts alone to be erroneous, and he rejects the claim that we can understand and explain everything in the terms of the empirical sciences, or even in the terms of one science. He castigates

the "intellectual tendencies, which uncritically hypostatize a field of investigation that is meaningful within its limits into a total science and infuse it with a religious attitude..." This erroneous and dangerous endeavour leads to doctrinaire and dogmatic attitudes and the "inability to explore in a genuine sense, to listen, analyse, test, and reflect on principles." Jaspers sees philosophy as inherent in the actual sciences themselves providing direction and meaning for the scientific enterprise. "If this guidance fails, science falls into gratuitous convention, meaningless correctness, aimless busy-ness, and spineless servitude." Jaspers feels that with the increasing specialisation of the sciences, the need for a discipline to tackle "the task of unifying the whole" is urgent. He clearly sees philosophy to be destined to fulfil this need.

6 *contradiction* = two statements which cannot both be true or both be false

(*A nurse is present - a nurse is not present.*)

contrariety = two statements which cannot both be true but can both be false

(*Mary is a registered nurse - Mary is an enrolled nurse.* But she may be neither)

subcontrariety = two statements which can both be true but cannot both be false

(*Wearing mufti on duty is not forbidden - wearing mufti on duty is not compulsory.* If both statements were false, then wearing mufti would be both forbidden and compulsory which it cannot be.)

indifference = the truth or falsity of one statement does not say anything at all about the truth or falsity of the other statement

(*At least one nurse here is not a man - at least one man here is not a nurse.* Even if the first statement were true, the second statement could still be either true or false, and vice versa.)

equivalence = the first statement implies the second statement, and vice versa

(*Some nurses are men - some men are nurses*)

superimplication = the first statement implies the second statement but the second statement does not imply the first one

(*John is a male nurse - John is a man.*)

subimplication = the second statement implies the first statement but the first statement does not imply the second one

(*Mary is a nurse - Mary is an efficient nurse.*)

7

Type of definition	Defined by -
real	naming things or objects
nominal	naming words, concepts, symbols
extensive	some lengthy explanation
ostensive	pointing or physical introduction
analytic	naming characteristic features
synthetic	indicating relations to other things or objects
equational	mathematical, symbolic means
descriptive	a combination of analytic and synthetic definitions
operational	adopting one meaning for a particular use or purpose
genetic	naming the cause of the thing or object or whence it arises

8 As an illustration of the importance which Socrates was seen to attach to examples taken from the daily life of his conversation partners, a very short passage from Plato's Republic yields references to medicine, cookery, sea voyages, crops, shoemaking, playing chess, bricklaying, music, buying and selling a horse or ship, banking money, boxing and fighting.

9 The distinction made between practical and theoretical philosophy and its relation to classical and modern ethics has been discussed in Part Two of this thesis.

10 The not very common inclusion of theology in this context is discussed in more detail a little later on in this part.

11 Apel (1953) lists "theology" in a standard German dictionary of philosophy as "the study of God; the science of religion", but 'science' meaning here what the German word *Wissenschaft* implies.

12 I have tried to think about Stevens' inclusion of the 'operational method' as an example of a philosophical method of enquiry as discussed in Part One, but I cannot really see it as part of the philosopher's repertoire. It is so clearly goal-directed that its predominant concern must be more the analysis of factual data rather than the analysis of concepts, meanings and logical relations; although the latter may be useful from time to time, a philosophical enquiry is not the central concern.

[13] Whiteley (1969) also emphasizes the need for philosophers to keep up to date with scientific developments since "Philosophy ... needs constantly to be taking account of the fresh scientific information to be accommodated in its total picture ... of our place in the world ...".

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PART FOUR

THE BUYERS

The potential development of nursing knowledge by relevant philosophical enquiries in nursing illustrated on hand of four fundamental philosophical tasks that need to be accomplished; that is, limiting the search for knowledge, thinking methodically and systematically about nursing, identifying the philosophical demands of the research process, and constructing and developing theories.

THE BUYERS

There are a great many ways in which one might determine the relevance of philosophical enquiries in nursing.[1]

Various nurse writers have explained, illustrated and exemplified why philosophical enquiries are needed to gain knowledge about nursing as a discipline and as a practice.[2] (Bloch 1975, Roy 1975, Donaldson & Crowley 1978, Griffin 1980, McFarlane 1980)

Having accepted that knowledge in whatever field of human endeavour may be most usefully and effectively gathered in some methodical way, nurse researchers have frequently pointed out when and how philosophical approaches are not only useful but essential to the research process. (Geitgey & Metz 1969, Hardy 1974, Jacox 1974, Johnson 1974, Batey 1977, Silva 1977, Krueger *et al* 1978, Crawford *et al* 1979)

Teachers of nurses have been concerned with aspects of curriculum development, and have utilized philosophical approaches to examine and clarify their endeavours. (Abdel Al 1974, Treece 1974, Chater 1975)

Nursing values and the ideology of the profession have been critically examined and occasionally redefined. (Partridge 1978, Gamer 1979)

Although all these contributions are valid and, indeed, important, I would like to consider the relevance of philosophical

enquiries in a different way by asking what *kind of philosophical tasks* have to be accomplished in nursing in order that the *search for nursing knowledge* may become coherent and may finally lead to the 'body of knowledge' which nurses claim they need for a necessary improvement in the effectiveness of patient care.

The *first task*, it seems to me, is to limit the search for knowledge to *nursing* knowledge;[3] that is knowledge which is identifiable by

- its explicit *nursing* perspective
- its structure and organisation based on a clearly articulated concept of *nursing*
- its demonstrable potential to improve patient care through *nursing* action.

Setting limits to the enquiries *in nursing* is an essential prerequisite for establishing the discipline of nursing. Disciplines are characterized by their distinctive realms of enquiry and learning, by a unique perspective and a distinct way of selecting and viewing phenomena in a definable field of enquiry.

Part of the endeavour to define the discipline of nursing must be to eradicate the confusion that generally appears to exist, in which nursing as a discipline, nursing practice, the nursing profession, and nursing 'science' are considered to be synonymous or largely interchangeable.

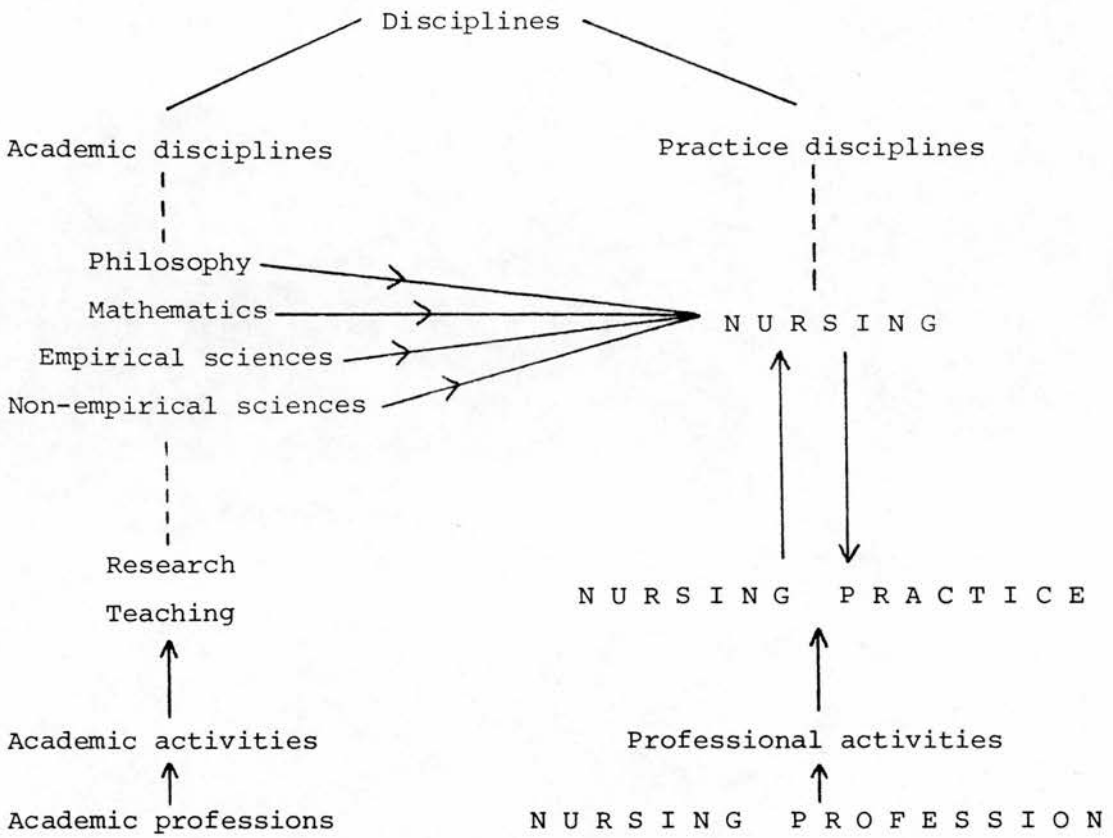
Nursing practice is not synonymous with the discipline of nursing.

The *discipline* of nursing consists of all those endeavours which are geared towards identifying, discovering, clarifying, ordering, and methodically *producing knowledge of a particular kind.*

Since one important characteristic of that knowledge is that it should improve patient care through nursing action, it seems reasonable to define nursing as a *practice discipline* (along with, for example, medicine, social work, law, education and the ministry).

Or to put it another way, the only rationale for the existence of a discipline of nursing is that there is an area of activity called nursing practice. But nursing practice (like other professional activities) does not draw *only* for relevant knowledge on the discipline of nursing. It needs knowledge from many different disciplines, to varying degrees and in different forms. But I would suggest that all such derived knowledge must be integrated by and in the discipline of nursing before it becomes wholly useful for the practice of nursing.

In establishing the proper relationship between nursing as a discipline, nursing practice, and other disciplines, one might begin by using a model capable of assimilating other essential features.



Although the discipline of nursing and the nursing profession are inextricably linked by nursing practice which for both constitutes their rationale for being, they must be distinguished from each other. What might be considered progress or advancement in one, need not necessarily lead to or be complemented by progress or advancement in the other.

Many of the 'problems' of nursing practice, for example, have been thought to be due to an insufficient recognition of the professional status of the nurse, which may well have been true. But obviously, not all problems in nursing practice appear to be diminishing (and some may well be increasing) in the process of professionalisation. One could even argue that the increasing

discrepancy between the advancement made by nursing as a profession and as a discipline may well be one of the main factors in what appears to some a lowering of standards in nursing practice.

If the word 'science' were used in the more general meaning of *Wissenschaft*, then the discipline of nursing would be synonymous with nursing science, but in its narrower sense by only referring to empirical methods of enquiry, it is not synonymous with the discipline of nursing.

Particular care should therefore be taken in talking about nursing science.

Similarly, *all* disciplines must be *research-based*, if research refers to all methods of enquiry, but they are not all based on 'scientific' research, if we confine the term to the use of empirical methods of investigation.

The main point which I am trying to make here is, that before we begin to define the realm of nursing as a discipline, we must have some clear conception of the nature of disciplines generally and of practice disciplines in particular.

If the discipline of nursing is grounded in nursing practice, as I have suggested, then its limits must be defined by a conceptualization of that practice.

Again, before any such endeavour at clarification may prove acceptable and successful, nursing practice itself must be conceptualized in relation to its purposes, means and ends, and

and its place in the society to which it belongs. What might emerge as a specific nursing perspective will undoubtedly be greatly influenced by the current beliefs and values of that society.

I do not wish to imply that all professional values reflect directly the values of the general society to which nurses belong (quite apart from the fact that the members of a profession in Western industrialized societies belong to very heterogenous social groups with many diverse value systems), but it seems quite urgent to me that nurses examine their professional systems of belief and establish to what an extent these concur with or diverge from the values of those members of society who are being served by the profession.

Whether a realignment of values where they diverge is necessary or desirable, should be a question of utmost importance in nursing. What one may well call an ideological analysis and revision must also include an honest appraisal of the extent to which values that are professed, are in fact internalized by the members of the profession. Sociologists have supplied some empirical evidence which points to a great diversity of people who belong to 'the profession'. This still leaves out the question by what values practice is to be informed which is carried out almost predominantly by workers who are not, or are not yet, members of the nursing profession.

In other words, the 'nursing perspective' may well turn out to be an illusion as far as its manifestation in practice is concerned.

A major point of my argument is that any endeavour, however diligently and skilfully executed, to create, find or produce *nursing* knowledge is doomed to failure until such a time when an identifiable nursing perspective emerges in nursing practice. Otherwise nursing as a discipline would become quite truly an 'academic discipline' (which is no pejorative for an essentially academic profession, for example, for philosophers, but which negates the whole rationale of a practice discipline).

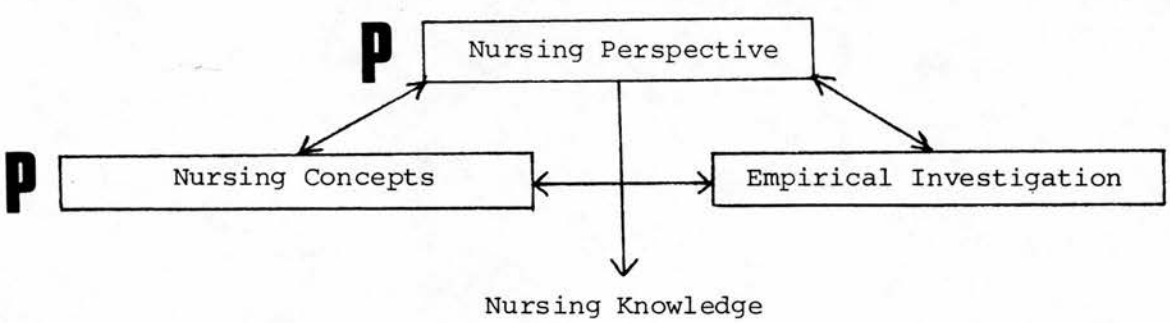
A clearly articulated concept of nursing and an identification of key concepts in nursing practice appear to be other, and consequent devices by which the limits of the discipline (and indeed, the practice) of nursing can be established. If this conceptualization of nursing were derived from practice, I would envisage a major reformulation of many theoretical frameworks for nursing practice and research. One 'conceptual shift' that might occur is the return to a central concept of 'illness' which may replace the present concept of 'health' as a *central* concern of nurses.

It seems to me that here nursing has followed a conceptual 'fashion' without clarifying the rationale and relationships embodied in the concepts of 'nurse' and 'patient'.

One might well argue, and with more congruence with the rationale of nursing as a service, that 'health' may well be *one* of the possible outcomes of successful nursing, but that 'illness' is really the central business of nurses.[4]

It is only when the discipline of nursing has been defined by a nursing perspective and has acquired a workable conceptualization of nursing that empirical investigations might demonstrate how certain kinds of knowledge within that perspective and based on those concepts may improve patient care through nursing action.

In this first task of limiting the search for knowledge to a search for nursing knowledge which should eventually lead to a true discipline of nursing, the two crucial aspects which determine the limits of nursing are only open to philosophical enquiries. I shall denote these in the following illustration by the letter 'P'.



The *second task* is to think methodically and systematically about nursing. This may have already been accomplished by some nurses but because of its essentially philosophical character, the result achieved by some cannot be 'handed on' to others as a

discrete item of knowledge. The conceptualization of a methodical and planned approach to the tasks which nurses perform with and for patients in the course of providing nursing care, has become known as the process of nursing.

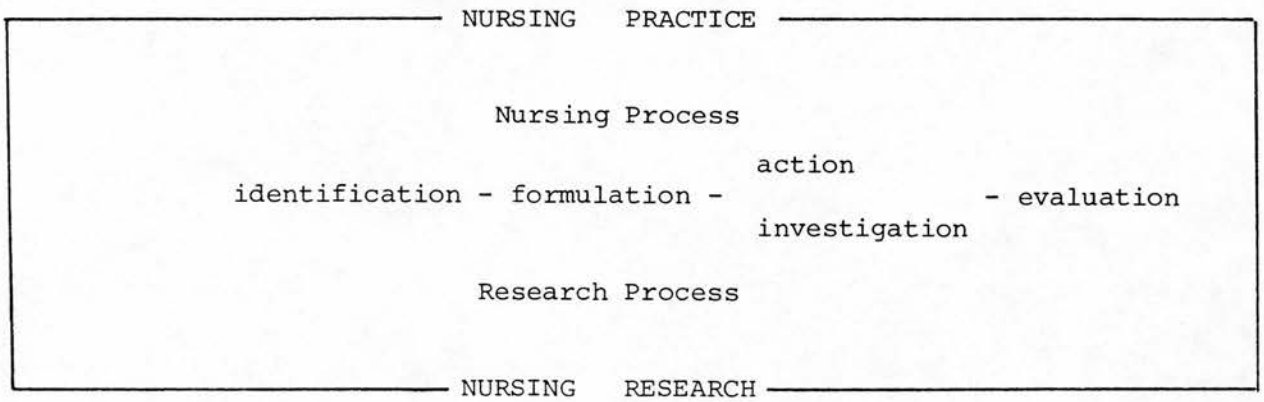
In its sequential phases of identification of patient needs, assessment of those needs which can be fulfilled by nursing intervention and of the personal and organisational resources available, intervention by carrying out certain nursing actions, and evaluation to ascertain the effectiveness of these actions, the process of nursing is clearly a programme of rational thinking and problem solving (closely akin to the solving of intellectual problems in an argument).

The forms of inductive and deductive thinking, establishing logical relations and pursuing a tenable argument are all based on philosophical methods of enquiry. Therefore these modes of thought must be practised by each nurse in order to be utilised in the planning of nursing care. It may well be that professional nursing practice will come to be identified by this ability to think clearly, analyse and synthesize various conceptual components and generally bring order into the whole picture of the patient's needs.

It is also through a process of methodical thinking that the necessary contribution from other disciplines to the solving of the presenting nursing problems can be identified.

A further aspect of this second task would be the *categorisation or classification of nursing problems*, so that relevant and valid means of solving them can be hypothesized, tested, and if found established, generalized in the form of principles of care.

It is quite obvious that the 'nursing process' parallels any other kind of methodical thinking in a problem- (or question-) orientated situation. It is therefore identical in its phases with the sequence in which knowledge may be obtained methodically and systematically, that is, with the 'research process'.



Whichever purpose this mode of thinking serves, it involves philosophical enquiries of one kind or another.

One specific point needs to be made here, if the research process is to provide the evidence that certain nursing actions have a demonstrable potential to improve patient care. The questions asked by the researcher must be formulated in the same, or in legitimately and easily exchangeable, terms in which the nurse practitioner formulates nursing problems.

In other words, there must be a 'fit' between the concepts and their relations employed by both pratitioner and researcher. Many examples of nursing research can be found where the concepts employed by the researcher are far wider or much narrower than those utilized in nursing practice. The problem for the researcher may well be that she needs to conform to customary formulations in other disciplines. But unless she can either 'transform' these concepts in such a way that they 'fit' into current conceptual schemes of nursing, or she can persuade workers in other disciplines to accept workable and valid nursing concepts (if their approval is needed), the results of her work will often be almost meaningless in nursing practice. But not only will they be practically useless, it will not be possible to enrich the thinking of nurses by incorporating the research into some ordered scheme of nursing knowledge.

It is also possible (and it has been done) that researchers influence the conceptualizations in specific areas of nursing practice. In 'action research' a continuing exchange takes place between the researcher and the practitioner. It may well be that this, and similar forms of mutual involvement in the search for nursing knowledge, will in time produce some methods of investigation particularly suited to the concerns of a practice discipline. Meanwhile, a reasonable test whether a researcher actually realizes the importance of this conceptual 'fit' may be that the choice of concepts and their relations are not only explained in terms of, say, psychological theory, but that they

are explored in terms of their current 'fit' with prevailing nursing concepts.

It is customary in empirical research to 'test' the proposed method of data collection by 'piloting' the chosen instrument. It would be equally feasable to 'test' and 'pilot' the proposed conceptual formulations which frequently could be amended and brought closer to the nursing perspective without losing their inherent validity in the context of another discipline. It seems to me that all these endeavours to establish methodical and systematic thinking about nursing must be accomplished with the help of philosophical methods of enquiry.

The *third task* is to identify clearly the philosophical demands of the research process. This should involve both the individual nurse researcher who needs to examine much more critically the theoretical foundations of her work, and the nurse theorist who needs to develop more detailed criticisms of current theoretical approaches, and who should be engaged in the construction and development of nursing theory.

Generally speaking, all scientific endeavours (in the widest sense) exhibit characteristics which are established by rational methods of enquiry as opposed to empirical ones. They must be coherent, definite, generalisable, true, logically ordered and reasonably argued.

Or to put it in a negative form, nursing science cannot be established by an explication of unrelated data, no matter how

valuable or interesting these may be in any one instance.[5] It has already been said frequently, that enquiries outwith a definite and definable field cannot be ordered into a coherent and conceptually sound entity.

The regression or reduction to generalisable statements, observations or formulated principles may vary considerably between different investigations, but it is the task of the researcher to reach the highest possible level of abstraction that the material allows.

The identification of conceptual relations which might emerge from the data is essential, if knowledge is to be gained and advanced. The researcher who 'plays safe' with an immaculate but totally unrelated and pedestrian presentation of her data does not challenge anyone to further the search for knowledge in that area.

The definition of truth is certainly a complex epistemological question but even if the 'whole' or 'absolute' truth (if one could define it) is not attainable, the researcher must at least abide by her own truth-conditions which the honest person will have established before, not after, the event.

Hypothesizing involves attention to the logical ordering of statements and to their particular relationship with each other. Again, a 'tidying up' operation after the investigation has been completed is not only somewhat dishonest, it also invariably shows in the logical disasters that almost always ensue. The

strengths and weaknesses of the proposed argument ought always to be made explicit to prevent unnecessary repetition or even compounding of error and to show, perhaps more importantly, how such strengths can be exploited and such weaknesses overcome. A reasonable grasp of, at least, informal logic seems to be a necessary prerequisite for any research endeavour. Epistemological questions and problems should be familiar to the researcher, at least in relation to her own field.

In any experimental form of research, metaphysical questions about 'cause' and 'effect' should perhaps be more generally considered before establishing criteria for measurements of whatever kind.

Causality may not be a necessary condition to establish in any case, and it is questionable whether it can in fact be demonstrated empirically.

The notion of inference should be handled carefully and with due regard for its inherent weaknesses which are rarely acknowledged in empirical work.

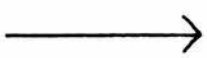
A particularly vexing question may well be to decide the meaning (*Bedeutung*) of the proposed research.

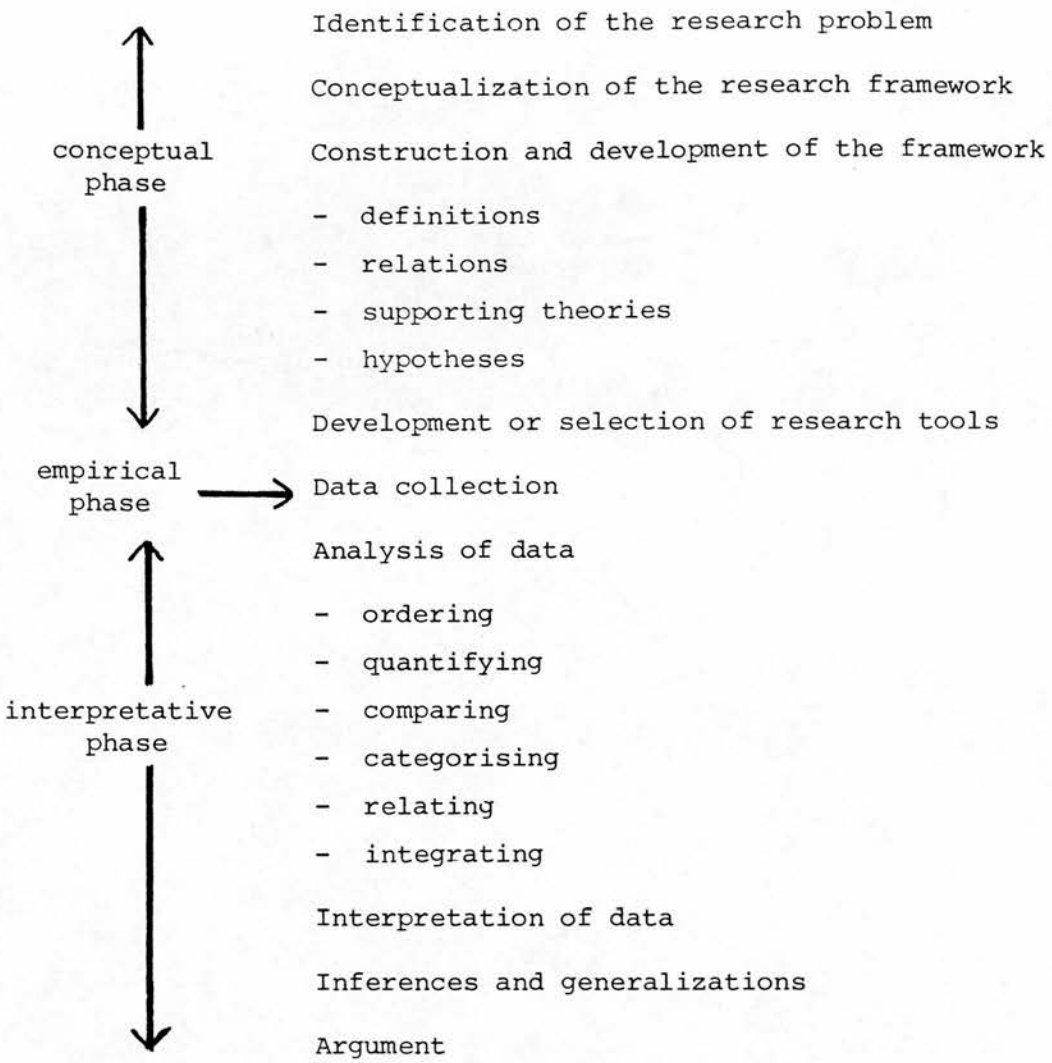
Trivialisation can hinder the advancement of knowledge rather than encourage it. To what an extent established criteria for rigorous definitions, complex but unwieldy tools of investigation, and minutely observable outcomes really contribute to knowing something worth knowing at the end, may demand difficult decisions.

But meaningless (*bedeutungslos*) research in a practice discipline is difficult to defend. The only 'defence' I can imagine might be that the investigation served a learning and training purpose. But even this defence (a moral argument should perhaps be developed from this point) is suspect if one asks for which kind of work the learning and training was meant to prepare the student.

Apart from these rather general considerations of any kind of research, it is in the process of research that the non-empirical aspects are often made less explicit than the empirical input.

Even a simplified outline will show that the non-empirical (that is, philosophically based) phases far outweigh the empirical phase (usually both in length of time the researcher needs to devote to them and in their importance for the coherence and meaningfulness of the whole enterprise).





In other words, the conceptual and interpretative phases seem to be far longer and more decisive in relation to the possible outcome than the empirical phase.

One question of interest in this argument must surely arise. How sound, especially conceptually and interpretatively, is nursing research as it is being conducted?

Batey (1977) examined twenty-five volumes of *Nursing Research* to assess the conceptual, empirical and interpretative limitations

apparent in the published material.

Of the limiting features identified, fewer were found in the empirical phase than in the two non-empirical phases. Furthermore, a large proportion of the seemingly empirical limitations could be related to somewhat suspect underlying reasoning in the conceptual phase of the research process. Very frequently, the selection of the investigative tool was incongruent with the meaning specified for the variable to be represented by the data produced with it.

Batey claims that

> "This was found to have occurred with greatest frequency when *the meaning of the governing concept remained blurred in the conceptual phase.*" (the italics are mine)

Limitations in the interpretative phase were mainly due to the attribution of meanings to the findings that were beyond the scope of the findings presented, to ignoring findings and holding to an initial value judgment despite the evidence, and to an absence of concept reexamination or reformulation on the basis of information.

> "As those comments imply, limiting features of the interpretative phase were traceable to a major extent again to the functions served by the conceptual design. *By far the largest proportion of limiting features of published research reports was attributable to the conceptual phase of the research process.*" (the italics are mine)

It may be instructive to list the limitations which apparently beset so many of the studies at their inception:

- fallacies of reasoning
- failure to specify meaning
- lack of substantive knowledge in conveying the problem[6]
- vagueness of conceptual framework
- lack of explicit statements regarding the purpose of the conceptual phase
- ambiguity in stating the problem
- uncertainty of what concepts had guided the choice of literature and its discussion
- ambiguity as to the meanings of the concepts used
- lack of explicit presentation of the investigator's conceptual image of the problem
- lack of relating important background knowledge about the problem to the study
- vagueness of the objective and rationale of the study, or its aims and purposes.

With the exception of the lack of relevant and important background knowledge (derived from other disciplines), all other limitations are clearly due to a fundamental inability to conceptualize nursing and to articulate conceptualizations clearly.

Batey suggests that this may be due to the fact that many of the studies served as learning exercises in research training. She comments

> "The majority of the texts that serve research instruction in nursing make at best only passing reference to the conceptual phase of the research design. Research instruction courses in nursing are limited for the most part to the technical components of research design as evidenced through procedures of data production and analysis."

Her observation that most research students receive no instruction in theory construction, or in logic and the philosophy of science, would probably be equally relevant to nursing research in the United Kingdom.

Yet these are the areas of philosophical concerns which provide the fundamental ingredients for research conceptualizations. There still appears to be a very simplified notion of 'empirical truth' abroad in nursing. This needs to be balanced by the very important concept of 'logical truth'.

The concepts and their meanings as they concern the phenomena of the study, require that relations be established between them. Such relations may be referred to as propositions, that is, proposed relations.

The investigator may propose certain associations or causal connections, but in either case, she has made explicit the fundamental rationale for the study, that is, she has stated its 'logical truth'.

The 'logical truth' as derived from the conceptualizations based on past knowledge and current perceptions can be 'disproven' in two ways: by someone pointing to its lack of conceptual completeness in representing the phenomenon's components and their relationships, or to its suspect logical inferences, and by available empirical evidence.

Knowledge which is valid, reliable *and* true emerges from an interaction between 'empirical' and 'logical' truths , each

informing and modifying the other.

It should by now be almost unnecessary to emphasize that 'empirical' evidence is highly selected, subjectively ordered and utilized according to some very definite preconceptions on the part of the selector, observer or investigator. Its 'truth-value' can only ever be measured against the 'truth-value' of the logical system which determined its selection, ordering and utilization. *Both* need to be subjected to constant scrutiny to allow congruence and cohesion between the two 'truths' to emerge. Either one is useless without the other.

The *fourth task* of theory construction and development is inherent in the already discussed research process, but I believe needs to be examined in more detail in its own right, since a long and often heated debate has accompanied the question whether there are or might be 'theories of nursing', 'theories for nursing' or 'theories in nursing', or whether perhaps there should be 'a nursing theory'.

Neither have the opponents who wish to distinguish between basic and applied sciences buried their differences. It seems to me that theories of whatever kind are a long way off in and for nursing.

I basically would see a logical division between 'theories for nursing' and 'theories in (or of) nursing'. Both seem to be needed by the practitioner of nursing.

Theories *for* nursing would include in my view, all kinds of theories offered by other disciplines which might contribute to an understanding of a *particular facet* of the patient's experience, the nurse's role, the institutional setting in which both nurse and patient interact, communicate and function, and the community which supports the institution with certain expectations, often quite divorced from its declared purposes. Examples of such 'applied' theories may include psychological theories about stress and anxiety, sociological theories about roles, status and function, socio-political theories about the power structure in institutions, and moral theories about the liberty of the individual or about the necessity to strive for a common good.

All of them would assist nurses to focus on, test and understand more fully certain aspects of their experience. However, it seems that nurses generally do not apply such theories to their practice although they have been taught about a good many of them.[7] My explanation why this should be so concurs with Crawford *et al* (1979) who suggest that

> "knowledge from another science or discipline cannot be adequately understood, if it is removed from the context that generated it. For this reason, when one uses borrowed concepts and theories, one must redefine and synthesize them according to the perspective of the borrowing discipline."

If this synthesis is a condition of employing theoretical constructs offered by other disciplines, then the primary task must be to create and define the perspective which will allow for a particular use of borrowed or applied theories. Therefore it

seems to be putting the cart before the horse to raise a great deal of concern about the proper classification of theories for nursing, before we can actually use them effectively in guiding and testing our observations in patient care, and in creating suitable experimental conditions for ascertaining the factual relationships postulated in those theories.

Theories in (or of) nursing cannot emerge either, until the first three tasks which I have described, are at least partially accomplished.

It seems to me that theory construction and development that is being conducted in the absence of a shared perspective with the practitioner of nursing, and which strives for a completeness of its own, is a mistaken exercise.

The function of a theory is primarily to guide observation and experiment by interrelated postulates or hypotheses which are subject to reformation and refinement.

In other words, observations and experiments are carried out in order to shed light on some theory.

In nursing, however, theories need to be further developed to be capable of guiding nursing actions towards desirable outcomes. Practice theory must go beyond the theories utilized in the empirical sciences which serve to define, explain and predict the behaviour of the inanimate or animate objects of the investigation.

Dickhoff and James (1968) describe such practice theories as "situation-producing", that is, as theories which guide action to produce a certain (generally agreed, desirable) situation.

> "Situation-producing theories ... attempt conceptualization of desired situations as well as conceptualizing the prescription under which an agent or practitioner must act in order to bring about situations of the kind *conceived as desirable in the conception of the goal.*" (the italics are mine)

In other words, practice or situation-producing theories *presuppose* an agreement on what are desirable objectives for nursing care.

It may appear to some that the desirable goals of nursing are perhaps quite easily identified and that it would not be too difficult to reach agreement on, for example, that a patient should emerge less anxious from an encounter with a nurse than he may have been before it.

Experiences of, and available evidence in my own field of nursing make me hesitant to expect such agreement to be either already existing or to be easily procured.

In order to meet the requirements of a practice theory as stipulated by Glaser and Strauss (1967), namely that

- it must closely fit the area in which it is to be used
- it must be understandable to practitioners using it
- it must be general enough to cover many diverse practice situations
- it must allow the practitioner control over the everyday situations as they change,

the first and second tasks as I have stipulated them here must be accomplished to some extent and on a wide basis by a great many members of the profession before practice theory can be constructed and developed.

However, if and when nurses engage in theory construction and development, they need to utilize philosophical methods and approaches in this task.

Concepts as the basic elements of theories need to be analyzed, clarified and meaningfully employed.

Theory consists of concepts, formulations about their relationships and postulates of a particular kind.

The nurse theorist must be able to determine the precise logical structure of the relations between the concepts employed in the theory (that is, its *syntax*) and their meaning in this context (that is, its *semantics*).

The syntax of the theory governs the propositions, expressions of the axioms, postulates, principles and hypotheses of a theory and their relationship to the concepts employed in it. The semantic structure of the theory (that is, how concepts are defined and understood) develops and changes as the theory develops and changes. Conceptual reappraisal therefore becomes a continuous and current task to be accomplished in any theory development.

The relationship between the elements of a theory (that is, its concepts) may be expressed in terms of analog, iconic or

symbolic (figurative) models. An understanding of the nature and function of such representations appears essential in theory construction and development.

Useful theories need to employ valid concepts (that is, concepts defined in a manner similar to that used by other theorists in the field), if they are to be successful in gaining empirical knowledge relevant to the field of enquiry generally. The operational and empirical adequacy of a theory rests on such notions as falsification, confirmation, verification, support, and corroboration. They all imply rather complex epistemological processes which need to be understood before operational or empirical adequacy can be demonstrated.

Finally, although the logical as well as the empirical adequacy of a theory may well be established, and all the criteria of a practice theory fulfilled, the users of any theory must be conscious of its continuing tentative nature.

More damage has been done in practice disciplines by the acceptance of a theory as if it represented established, immutable facts than by what one might call theoretical pragmatism.

In concentrating on what I see to be essential tasks to be accomplished in the search for nursing knowledge, that is

- to limit the search for knowledge
- to think methodically and systematically about nursing
- to identify clearly the philosophical demands of the research process
- to construct and develop nursing theories,

I have left out many philosophical concerns in nursing. Perhaps I should say more accurately that I have not made some of them as explicit as they deserve to be made when I concerned myself with the above tasks.

I will therefore at least indicate what I consider to be important and relevant philosophical problems that will emerge in the process of searching for nursing knowledge.

One of the major problems accompanying practically all the tasks which I have mentioned is that of *belief* and *knowledge*. Are there unjustified beliefs and others which can be justified by reasoning? In what particular way are justified beliefs transformed into certain knowledge?

Here a second fundamental problem emerges which centers around the notions of *probability* and *certainty*.

There is an inherent dilemma which afflicts all scientific enterprises. On the one hand the aim of scientific enquiries is to provide us with knowledge which we can trust and about which we can be sure enough in order to act confidently and to predict future outcomes. On the other hand it is essential feature of scientific investigations that we should never believe anything dogmatically[8] and that we must be ready to change our beliefs in accordance with what we observe and what we reason.

Therefore we should not be confident about any scientific theory which we should abandon if it proves contrary to observation or argument.

So how are we to understand certainty and probability? Are they incompatible with each other or does one lead to the other? Can I be certain of some aspects of a situation and remain dubious about others, and if I do, how does this affect my overall perception and conceptualization of that part of my experience?

Here another problem emerges that will become apparent in almost all the tasks which I have identified.

How do *perception* and *conception* relate to each other? Knowing about the unreliability of human perceptions, how would this unreliability affect the conceptions which are based on our perceptual experiences?[9] To answer this question, we would again have to examine in what circumstances and by what criteria our perceptual interpretations (beliefs) can be reasonably justified.

We would have to examine the *process of justification* which we use to establish the reliability of our perceptions.

Another difficult problem of particular relevance to nursing may be the question whether unexpressed conceptions inform our thinking (and consequently our actions) in a different way to expressed conceptions.

Here I am thinking of the possibility that a nurse may be apparently unable to express verbally what she means by, for example, 'comfort' and how she utilizes this concept in caring for a patient. Although she may not be able to identify the criteria by which we might distinguish states of 'comfort' and 'discomfort', is it possible that she *consistently* and *selectively* engages in appropriate

actions which actually make people more comfortable than they were?

What I think to be pertinent here is whether expressed and unexpressed conceptions have the same logical power, or perhaps one might say, are equally rational.

Another important aspect of all epistemological enquiries is what kind of *explanation* might be required. We may need to distinguish between 'how' and 'why' explanations, or between descriptive and analytical ones. We might also need to distinguish between explanations and solutions. We should also examine (in the view that nursing is a practice discipline and therefore best served by practice or situation-producing theories) whether or how explanations become directives for action.

This examination appears to me especially important in view of the fact that in many situations in health care particular importance is attributed to the need to explain. But often, it seems, an explanation is offered with the intention that the recipient of it consequently *acts* in a particular way.

I would argue that an explanation *per se* does not necessarily imply any particular way in which action should follow, or indeed, whether any action should or need follow at all.

To take a very common example, nurses have known the explanation how bedsores may develop, for a long time but this knowledge derived from often given explanations has not led to nurses acting in a particular way in their endeavours to prevent the

occurrence of such bedsores in patients.

We certainly need to distinguish between trivial and important, implausible and plausible, partial and full explanations. Finally, we must establish the relationship between explanations and meaning.

In almost all endeavours which aim at gathering knowledge about people as contrasted with knowledge about things, *moral judgments* (whether made explicit or not), are part of our beliefs, certainty, perception and conception, justification, and explanation about the matter in hand.

Whether we judge what is 'right' in nursing or 'good' or 'desirable', we are making judgments about values which may be implicit or explicit.

It may depend much on the subject of the investigation to what an extent the investigator makes the moral components of the situation explicit. An enquiry into how and why nurses communicate potentially distressing information to patients (or on what grounds they decide to withhold such information) may demand more obviously an explication of moral concepts and an examination of moral judgments. But I would suggest that these should be made explicit in all nursing enquiries, to the same extent to which researchers explain and justify their factual evidence and the ways in which it was gathered.

My attempt to examine the *relevance* of some philosophical enquiries to nursing may appear limited, since I have largely concentrated on conceptual and epistemological questions. I was certainly tempted to look, for example, much more closely at the kind of moral questions which I feel nurses ought to be asking. On reflection, however, I think that these would have to emerge as the tasks which I have described, are being gradually accomplished.

By emphasizing the contributions which philosophical methods of enquiry might make in limiting the search for knowledge, in thinking methodically and systematically about nursing, in identifying the philosophical demands of the research process, and in theory construction and development, I have offered a possible answer to the initial question which led me to engage in this argument.

A new phenomenon in nursing is the search for a particular kind of knowledge. Some nurse writers claim that in addition to various empirical methods of investigation, philosophical methods of enquiry are needed to accomplish the set task. By concentrating predominantly on the process by which knowledge is gained (that is, the research process), and by discussing the fundamental necessity for philosophical enquiries of a particular kind in almost all its phases, the primary philosophical tasks have been much more clearly identified, I would claim, than by ranging wide over all that philosophy might have to offer.

My aim has been to show the *starting points* for philosophical enquiries in nursing rather than define their ends.

Rather than pretend to a certainty which I do not possess, I have suggested possibilities which might make us more certain in the end, if we are courageous and adventurous enough to explore them.

> "Philosophy, though unable to tell us with certainty what is the true answer to the doubts which it raises, is able to suggest many possibilities which enlarge our thoughts and free them from the tyranny of custom. Thus, while diminishing our feeling of certainty as to what things are, it greatly increases our knowledge as to what they might be; it removes the somewhat arrogant dogmatism of those who have never travelled into the region of liberating doubt, and it keeps alive our sense of wonder by showing familiar things in an unfamiliar aspect." (Russell 1967)

NOTES TO PART FOUR

1 I would like to make a clear distinction here between the relevance of philosophical enquiries *in* nursing and *to* nursing. The purposes of philosophical enquiries *in* nursing should *directly* relate to the processes by which nursing knowledge is gained. Criticism, analysis, conceptual experimentation, clarification and synthesis should be seen as tasks to be accomplished in the discipline of nursing. There still remain other philosophical enquiries, both 'theoretical' and 'practical' which might be relevant to nursing. They may be concerned with very general philosophical enquiries and may contribute indirectly to the advancement of nursing knowledge by making some aspect of our general reality more intelligible or by making us more sensitive to important issues. Or there may be philosophical enquiries related to other disciplines, for example, to science, social science and history, which may not only make us more aware of the nature of knowledge derived from these disciplines, but which may also serve as examples how similar epistemological problems may be examined in nursing.

2 The writers mentioned here explain philosophical enquiries in what I consider to be a legitimate way to talk about philosophy. They do not commit the errors which I have exemplified in Part Two of my argument.

3 I need to point out here that my argument for limiting the search for knowledge to *nursing* knowledge is not synonymous with arguing that nurse researchers should not be engaged in other kinds of enquiries. There may well be a moral or socio-political argument for circumscribing the activities of practice-orientated researchers generally, or even in nursing particularly, but this is not one I am pursuing at the moment. There may be equally sound arguments for encouraging nurses to research in other disciplines. Donaldson (1978), for example, observes that "some members of the profession must engage in enquiry that is not immediately applicable to current clinical practice", and "Appropriately prepared nurses may elect to conduct research within other disciplines because of the critical importance of this non-nursing research to professional practice or the growth of the discipline (of nursing)." All I am saying here is that nurse researchers who wish to produce nursing knowledge directly must limit their search for this knowledge in a particular way.

4 There are many reasons why I believe the central emphasis on 'health' to be a mistaken one in nursing. In particular, 'health' is a long term goal which might inform our choices in many areas of our lives, and which undoubtedly will influence

such choices in very specific ways when we are ill. But it is also a particularly global concept which tends to be employed in an idealistic and all encompassing sense, thereby often obscuring the more immediate short term goals of a sick person. If one believes as I do, that nursing is an activity through which a sick person is assisted in living through a short or long term episode of illness with a minimum of distress and pain as can be achieved, then nursing is essentially a 'here-and-now' concern orientated towards the current illness experience of the patient. In what one might call the experientially (perhaps even existentially) orientated endeavour of nursing, more can be accomplished by concentrating on a succession of short term goals (which may well be informed by the long term goal of 'health' but not necessarily so). The identification of these short term goals may be more readily achieved by conceptualizations of facets of an illness experience like distress, pain, discomfort, and desolation.

5 This criticism of the explication of unrelated data is not meant to disparage small-scale investigations concentrating on very specific problems or questions which may well not be immediately generalisable to any extent. I am here thinking of in-practice investigations by practising nurses or nurse teachers to solve fairly concrete nursing problems in a specific and perhaps very circumscribed field of nursing. These are not only valuable for the immediate purpose which they are meant to serve, they must also be a valuable source of nursing conceptualizations derived from practice, and they may well be the most effective way to develop methods of investigation especially suited to the needs of a practice discipline. Not only should such small-scale attempts at gaining knowledge be encouraged, but we should also look for ways by which such investigations can be utilized more widely.

6 I do not think that Batey is using the notion of 'substantive knowledge' here in the sense earlier referred to by me as indicating the conceptualizations that fit a discipline's perspective and that may be represented in its models and theories. In the context of her argument, it appears that she is indicating a lack of using available, current, considerable, important and valuable knowledge relevant to the problem to be investigated, that is, substantial knowledge.

7 My perplexity why nurses do not appear to utilize relevant theories from other disciplines is caused by various aspects of this phenomenon. One major difficulty, I believe, is created at the very outset when nurses are taught about such theories. Not only are the theories of other disciplines often removed from the context in which they were generated, simplified to the point of distortion, and often not related

to any kind of nursing experience, they are also frequently presented *as if they were facts*. This removes any possibility that even an intellectually curious nursing student may apply them to certain aspects of the nursing experience in order to test their utility, reasonableness, and explanatory and predictive powers.

8 A much more simplicistic conception of science appears to prevail among many non-scientists (and even perhaps among a few scientists) which nurses generally tend to share. There is often almost an element of unshakable faith in scientific findings which are accepted as certain and immutable knowledge.

9 I am not sure whether my formulation seems to imply that there are conceptions which are based on something other than perceptual experiences. If this should be so then I would need to emphasize that all conceptualizations are based or derived from experience. I would further argue that all experience involves perceptual processes, so consequently all conceptualizations must be derived in some way from perceptual experiences. I am beginning to wonder whether there is not a tautology hidden somewhere in talking about perceptual experiences.

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EPILOGUE

In developing my argument concerning the meaning and relevance of philosophical enquiries in nursing, I had a picture in my mind in which I saw nurses on a journey, searching for knowledge. In the market place of knowledge, some nurses are offering wares which do not seem to be very genuine, while other scholars tempt us with potentially useful kinds of knowledge. But these we need to refashion in some way to make them actually usable for our own purposes.

Amongst the sellers are philosophers who really ask something quite different of their customers who wish to purchase the commodity called philosophical knowledge. Philosophers show us what kind of things they produce but then they refuse to sell us their products. Instead, they tell the buyers of knowledge to go away and produce their own.

So where do we go from here?

Who should produce the knowledge that can be gained by learning and emulating the skills of philosophers, and which appears so essential in allowing us to proceed on our journey in search of nursing knowledge?

I have talked a great deal of the necessity for many nurses to participate in philosophical enquiries, and especially of the need for the nurse practitioner to do so. It also seems necessary that those whose main task it is to produce knowledge, acquire the

philosophical skills to accomplish this task.

So does this mean that all nurses, practitioners and researchers alike, need to become proficient nurse philosophers? I would hardly think so, quite apart from the fact that it does not appear to be a very practicable proposal to make. I do think, however, that all nurses need to participate at some level and to some extent in accomplishing the essential philosophical tasks which I have outlined earlier on.

Perhaps the most general requirement that needs to be met by all nurses is to think methodically and systematically about nursing, and to develop the ability to make explicit fundamental conceptualizations in nursing practice.

To achieve this, I would not suggest that nursing students should study 'philosophy' or any of its branches in a formal manner. What I would expect to be necessary is that they are given the opportunity to learn about *nursing* in a methodical and systematic manner, to acquire habits of thought that develop their logical and critical powers, to learn to structure their arguments, to develop a critical approach to apparently 'certain' knowledge, to look for and find relevant knowledge rather than to accept passively preselected information, and not least of all, to become consciously involved in using appropriate and relevant results of nursing research. To put it all much more simply, the task to be accomplished by all nursing students is to think clearly, logically, consistently and coherently about nursing.

Only if and when we achieve this goal, will nurse practitioners emerge in sufficient numbers who can conceptualize their practice and who can make the perspective of their work explicit.

Nurse researchers need to participate at a different level and to a greater extent in accomplishing other and additional philosophical tasks. They need to be able to identify clearly, and fulfil competently, the philosophical demands of the research process, and to construct and develop nursing theories.

I am reasonably convinced that part of any learning which the research student has to do must include recognizable and distinct efforts to become competent in some aspects of logic, in identifying and working through epistemological problems, and in utilizing philosophical methods of enquiry with the same deliberation and conscious choice that characterizes the use of empirical methods of investigation in any sound research.

There is also a need for some nurse researchers not to allow themselves to be diverted from non-empirical enquiries in nursing by narrow definitions of what constitutes a scientific endeavour.

Finally, there may well be a need for nursing research establishments to change the focus of their work from nurses who do research to nursing research.

I would envisage greater success in creating the discipline of nursing with its substantive and syntactical structures, if nursing research establishments (including academic departments of nursing as part of their research commitment) would see it as

their primary concern to accomplish the essential tasks which I have indicated.

This would create the basis for stable investigative endeavours by nurse researchers whose primary interest lies in *nursing* research and the discovery of *nursing* knowledge, and who should find a place among their number for the nurse historian and the nurse philosopher.

The purpose of having nurse philosophers and historians is not to duplicate the efforts of other disciplines, but to ensure the development of the discipline of nursing.

It is only through the integrated efforts of the philosopher, the historian, the empirical scientist and the professional practitioner that nursing knowledge can be gained, developed and advanced, and the discipline of nursing be created. Only when there *is* a discipline of nursing, can we find out whether the patient does or does not benefit from nursing care that is based on identifiable nursing knowledge.

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APPENDICES

APPENDIX I

Schröck, R.A.

A question of honesty in nursing practice

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A question of honesty in nursing practice

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A question of honesty in nursing practice

This paper examines the perception of moral issues in nursing as presented in the literature and in themes of meetings, discussions and study days devoted to the subject. It offers an account of moral issues perceived by nursing students and qualified nurses as being relevant to discussions of moral aspects in nursing. The second part of this paper presents a closer examination of the problems related to professional truth telling and deception as an illustration of an 'everyday' moral issue in nursing and in health care generally.

VALUE JUDGEMENTS

Health care workers make numerous value judgements in the course of a single day. Occasionally they may be conscious of doing so, more often than not decisions are arrived at by the individual without conscious awareness of the process involved in them. It has been claimed that all decision making processes involve value judgements (Steele & Harmon 1979) and it is widely agreed that health care priority choices inevitably entail moral judgements (Campbell 1978). Making any decision, however weighty or relatively trivial, implies that the person who needs to decide has recognized the possibility of at least two potential courses of action. If one does not respond almost immediately in a particular way to an event or to a situation, but pauses for thought to contemplate even briefly what one should do or say, it is more than likely that one has become aware of a conflict of interests. The not inconsiderable literature on value and moral questions related to nursing clearly illustrates the various interests that may emerge when nurses become (or are made) aware of having to decide on one course of action in preference to another. Value or moral judgements must be made in answer to questions of what is right or wrong in any given situation, where any degree of uncertainty exists as to the course of the 'right' action. (The earlier premise that all decision making involves value judgements, is extended in this paper to the contention that all value judgements are moral judgements.) When one keeps in

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mind these two attributes that largely characterize a moral dilemma, namely uncertainty and conflict of interests, it should not be at all difficult to think of many events in a nurse's daily professional life that might serve as illustrations. It should therefore be a matter of some interest that most of the writings, meetings, discussions, study days and slots in the nursing student's timetable which are devoted at least occasionally to 'moral dilemmas in nursing', by and large use examples of experiences and events which cannot in any sense be described as everyday happenings. Few nurses have to face with any frequency actual conflicts and decisions concerning abortion, human experimentation, organ transplantation, euthanasia, psycho-surgery or even resuscitation in their daily work. Yet almost invariably these are the predominant topics when the concept of moral dilemmas is applied to the professional activities of the nurse, or of the doctor (Campbell 1975).

There may be many and complex reasons why much more common moral problems are largely ignored by writers and those who initiate discussions in this area. Honesty, keeping promises, respecting physical and emotional privacy, safeguarding adult entitlements, doing justice to people, examining the limits of obedience, using and not abusing professional power and preventing incompetent practices may not be dramatic enough at first glance to sell books or to attract people to a meeting or study day. It may also influence the choice of topics that it is usually easier for all concerned to talk about events and situations which are largely hypothetical for most of the participants and therefore can be dealt with on an 'as if' basis without any personal commitment or action likely to affect next day's work. Neither is it inconceivable that nurses might recognize more immediate moral problems and issues and would prefer to be concerned with them, if they were given the opportunity to do so.

SOME NURSES' PERCEPTIONS OF MORAL ISSUES IN NURSING

In an attempt to elucidate and examine nurses' perceptions of moral problems which they have encountered or feel that they might do so in their daily professional activities, groups of nursing students and qualified nurses in postbasic programmes were asked during a 9 month period between September 1978 and June 1979, at the beginning of a series of timetabled discussions concerned with moral aspects of nursing, 'to list three topics or issues you think might be relevant to the forthcoming series of discussions' which varied in number between five and eight sessions. Table 1 provides a summary of the answers received by 83 undergraduate nursing students and 48 postbasic students who were participating in health visiting, clinical teaching and nursing administration courses.

Although the respondents were all, at the time, attending nursing courses in an institution of higher education, there is little reason to believe that they were entirely unrepresentative of nurses generally, in offering over 90% of topics for discussion which are usually presented as illustrations of moral concerns in nursing by the professional literature as well as by the mass media.

TABLE 1 *Moral issues perceived by nursing students and qualified nurses as being relevant to discussions of moral aspects in nursing*

Student group	*Number of students*	*Number of topics offered*	*Number of topics related to:* *Abortion*	*Resuscitation*	*Organ transplantation*	*Euthanasia*	*Psychosurgery*	*Others*
Undergraduate nursing students								
Year 1	29	87	29	15	14	21	0	8
Year 2	20	60	18	20	8	10	1	3
Year 3	20	60	12	18	10	8	4	8
Year 4	14	42	13	10	4	10	2	3
Health visiting students	20	60	17	20	9	11	0	3
Clinical teaching students	12	36	12	12	1	9	1	1
Nursing administration students	16	46	11	10	6	11	1	7
Total	131	391	112	105	52	80	9	33
% of all topics offered	—	—	28·6	26·9	13·3	20·5	2·3	8·4

The category of topics that was of particular interest in the context of the presented argument is that of 'others' containing topics not related to the often cited examples of moral conflict in nursing. In spite of the small number of topics in that category (well under 10%), Table 2 shows an interesting difference between nursing students and qualified nurses in their choice of examples.

TABLE 2 *Less commonly-mentioned topics, perceived as being relevant to discussions of moral aspects in nursing*

Student group	*Number of 'other' topics offered*	*Number of 'other' topics related to: Medical authority*	*Patient's property*	*Fellow nurses*	*Patient care*	*Patient's relatives*
Undergraduate nursing students	22	3	1	5	7	6
Health visiting students	3	1	0	0	0	2
Clinical teaching students	1	1	0	0	0	0
Nursing administration students	7	1	3	1	1	1
Total	33	6	4	6	8	9
% of all 'other' topics offered	—	18·2	12·1	18.2	24·2	27·3

The comparatively high proportion of topics relating to patients' relatives and patient care, is somewhat misleading as an overall indication of concern amongst nurses with moral issues in these areas, since 76% of these topics were offered by nursing students, 12% by health visiting students and 12% by nursing administration students, while clinical teaching students did not contribute at all to these areas.

Topics related to 'medical authority' included giving a drug without a doctor's prescription, criticizing a doctor for not answering a call, not telling a doctor something that a patient had said, and giving the patient information which the doctor had withheld deliberately.

Conflicts arising out of caring for the 'patient's property' were described as losing an item of personal clothing in the ward, allowing the patient to keep a large sum of money in the bedside locker, not checking all the patient's property on admission, and handing patient's property to visitors without his or her knowledge.

'Fellow nurses' were seen as part of a moral dilemma when they did not carry out nursing care as instructed by the ward sister, were abrupt or unkind to a particular patient, made mistakes but did not admit to them or attempted to blame others for errors or omissions.

Nursing administration students contributed one item which related to

'patient care' giving the example of not telling the patient when he or she might go home. All nursing students who offered items in this category mentioned insufficient or ineffective care due to too much work, poor organization, ignorance, tiredness, home commitments of nurses, and frequent transfers of staff between wards. Similar problems were indicated in relation to 'patient's relatives' whom nursing students felt they had failed due to ignorance, direct prohibitions by the senior ward staff to pass on information, not being able to conceal when relatives were felt to be in the way; and not knowing what the patient feels about his or her relatives. Both responses by health visiting students in this category questioned the general notion that relatives are always good for patients.

Perceptions

If one examines the perceptions implied in those topics offered which did not fall into the more common categories of moral dilemmas, one experiences difficulties in judging whether the respondents perceived a situation in moral terms rather than in what might be more appropriately called social–organizational contexts. However, even a closer look at the 'in any case' small numbers of responses in this category reveals the almost total absence of what may be called more justifiably 'everyday moral issues'. There are many glaring omissions; telling the truth, keeping promises, respecting privileged information, defining the limits of obedience owed to a formal professional authority, and balancing justifiable self-interest against that of the patient. All these activities are not only part of everybody's daily existence, they also appear to be much more central to the patient's concern about the 'right' and 'wrong' decisions that are made by others and over which he or she appears to have little control.

The second part of this paper offers a closer examination of some of the problems related to professional truth telling and deception as an illustration of an 'everyday' moral issue in nursing and in health care generally, to which nurses might address themselves rather more frequently than they seem to be doing at present.

The cavalier approach of the health care professional to being truthful

Whether to lie, be silent, hedge around or tell the truth is often a difficult decision to make. Almost everyone who remains conscious of the various shades of truth that pervade our everyday existence must have faced the personal dilemma whether to be truthful or not on many occasions. Few nurses would claim that they never had to modify the truth as they knew it, in what they genuinely believed to be the patient's best interest. Doctors and nurses may not feel able to concur with the fourth century Augustine who concluded a treatise 'Against Lying' by saying 'what is not true we should never try to persuade anyone to believe' (Deferrari 1952). Socrates, some 700 years before Augustine, illustrated the dilemmas of being truthful in a way that nurses may appreciate: ' . . . If one borrowed a weapon from a friend who subsequently went out of his mind and

then asked for it back, surely it would be generally agreed that one ought not to return it, and that it would not be right to do so, or to consent to tell the strict truth to a madman?' (Plato 1955 edition). From Socrates to Kant and Simone de Beauvoir (1969), who all cited examples from the work of physicians and nurses, philosophers have examined the principles which appear to or perhaps ought to govern man's decisions to lie or tell the truth.

This was never an easy undertaking and many are the examples in which 'The common good requires that even falsehoods should be upheld' (Grotius quoting Quintilian 1925).

'Where deception is designed to benefit the person deceived, common sense seems to concede that it may sometimes be right: for example, most persons would not hesitate to speak falsely to an invalid, if this seemed the only way of concealing facts that might produce a dangerous shock . . .', argued Sidgwick (1907). 'Telling the truth, therefore, is not solely a matter of moral character, it is also a matter of correct appreciation of real situations and serious reflection upon them. The more complex the actual situation of a man's life, the more responsible and the more difficult will be his task of telling the truth' (Bonfoeffer in Bethge 1965).

Nurses might argue with justification that they find themselves in very complex situations where many quite legitimate interests may conflict with one another. But it seems that the appreciation of the potential complexity of the nursing task has not been accompanied by the 'serious reflection' which Bonhoeffer demands.

'Many physicians talk about such deception in a cavalier, often condescending and joking way, whereas patients often have an acute sense of injury and loss of trust at learning that they have been duped' (Bok 1978).

This casual approach to the problems of professional truth and deception is common to all professions causing the recipients of professional services the greatest distress. For patients among others, to be given false information about important events in their lives is to be rendered powerless and to be deprived of their autonomy.

'Honesty from health professionals matters more to patients than almost everything else that they may experience when ill' (Bok 1978).

Yet the requirement to be honest with patients is not referred to either in the nursing or in the medical code of ethics! It is generally ignored, if not actually disparaged in the teaching of nursing and medicine and finds only an occasional reference in writings on professional ethics.

THE FUNDAMENTAL EXPECTATION OF TRUTHFULNESS IN SOCIAL AND PROFESSIONAL INTERACTIONS

Some level of truthfulness has always been seen as essential to human society. A society whose members were generally unable to distinguish truthful messages from deception would collapse. There must be a minimal degree of trust in essential truthfulness of communications with one's fellow men. Daily life as most

people know it would come to a standstill, if they could not rely at least in principle on the truthfulness of others. The procuring of food and shelter could not be accomplished by simply asking where they might be found, warnings of dangers or pleas for help would have to be ignored until or unless independent confirmation could be found.

Doctors and nurses can only practise on the general understanding that patients will tell the truth about their complaints and problems. A nurse could not accomplish the most basic care, if she could not expect that patients indicating hunger, thirst, need for elimination, discomfort and pain are normally telling the truth.

It is the necessary expectation that people will be truthful, which also confers upon the lie or half-truth the power to hurt and to destroy the trust that is essential in the professional relationship. Not only does lying or deception rob the patient of his or her autonomous power, it decreases in the long run the power of the nurse or the doctor to act effectively for the benefit of this and other patients. Few nurses may deliberately lie to patients but the common uses of half-truths and denials (often as a result of the nurse's inability to cope with a potentially stressful situation) must be truly anti-therapeutic over time.

Excuses and justification

The perpetrator of the lie or half-truth usually incorporates in the decision to act in this way some explanation to assuage his own conscience, or he may offer some explanation to others who may require that he explains his conduct. It might help to clarify the issues involved by making distinctions between the kinds of explanations usually given by a professional person who has lied to a client.

An excuse seeks to extenuate the person who told a lie from any blame. The nurse who told a patient on little or no evidence that a particular treatment would cure him, while others who feel that this is not really an honest presentation of the situation might claim as an excuse that so little is known about the treatment to make it impossible to say that what she had told the patient may not be true. In other words, the nurse is not really offering an excuse for having lied but is disputing that her action should be classified as a lie.

A second type of excuse might emerge, if she claimed that she knew well that what she had told the patients was not entirely true, but that she had been ordered by the doctor to give the patient the information in this particular form. A third type of excuse may be that she admits to having deceived the patient and therefore accepts responsibility for it, but offers reasons to show that there was some justification in her decision to lie to the patient.

It may be apparent that an examination of the justification of the nurse's action would have to proceed along different lines, depending on what type of excuse had been put forward by her.

Not knowing the whole truth should not prevent anyone from being told what is actually known and what can reasonably be conveyed to the person by the informant.

Doctors frequently justify their reluctance to give a patient information about his illness by claiming that to tell the 'whole truth' would not be possible. All that is known about the disease may not be known by the individual doctor. Even all that he does know about could possibly not be conveyed to the patient in less than weeks or even months. Probably what can be said about the disease generally needs so many qualifications and elaborations in each individual case that the task of 'telling the truth' appears quite impossible. Clearly, 'the whole truth' is out of reach for the doctor, for the patient, and for the nurse in the above example.

However, the issues to be judged are not concerned with the 'whole truth' but with the truthfulness of the nurse who, her colleagues might argue, should have told the patient truthfully that little was known about the treatment in question.

The first type of excuse would therefore entail an examination of whether the nurse was justified in claiming that no more certain knowledge about the treatment was available to anyone and whether she was justified in concealing the uncertainty of the treatment from the patient. The second excuse would pose quite different questions related to the moral issues of the limits of obedience to a formal professional authority and of acting on moral decisions made by another person (assuming that the doctor felt morally justified to withhold the truth from the patient). The third type of excuse would lead to an examination of the validity of the moral reasons for deliberately telling a lie to the patient. The nurse may have decided not to be truthful in an endeavour to avoid harm and produce a benefit to the patient which she felt could not have been achieved by telling the truth.

One might argue that the first and second type of excuses do not provide any justification for telling a lie to this patient, one being a matter of possible ignorance or unjustifiable bias in relation to facts, the other being a question of self-interest rather than of the interest of the patient. If any justification can be found for the action of the nurse, it would most likely have to emerge from the third type of excuse. To put it another way: ignorance and coercion are not acceptable justifications for lying to patients, if the perpetrator of the lie claims to have acted in a professional capacity which is characterized by the demand for a reasonable standard of knowledge and by a reasonable degree of autonomy of action. Nurses cannot claim professional status and at the same time excuse their actions by ignorance and coercion.

The deliberate lie indicated in the third type of excuse in which the nurse admits the lie, accepts the responsibility for it but offers moral reasons why she should not be blamed for the *decision* to deceive the patient rather than tell the truth, appears to be the only possible departure from truthfulness by a professional person that might be justified.

THE PROCESS OF JUSTIFICATION

If accountability is accepted as a characteristic of a professional performance, then all departures from generally expected and established principles of practice

should be justified. It was pointed out earlier that the principle of telling the truth is essential to maintaining an effective professional relationship. Any deliberate deviation from this principle should be justified and not be accepted without questioning the rationale employed by the professional who decided on a specific occasion not to tell the truth.

In examining the offered justification when presented with a fellow nurse's excuse for a particular lie, her professional colleagues should first of all look carefully whether any alternatives of a non-deceptive nature had been available. Secondly, they would weigh the moral reasons for and against the lie taking care to consider both the nurse's and the patient's perspective. Thirdly, they would look beyond the individuals involved and assess the effect this and quite possibly consequent instances of deception ensuing from the first one might have on other persons outside the specific situation under discussion.

'Reasonable persons might be especially eager to circumscribe the lies told by all those whose power renders their impact on human lives greater than usual. And they would wish to set up the clearest possible standards and safeguards in order to prevent these and other liars from drifting into more and more damaging practices—through misunderstanding, carelessness, or abuse.

The concern to counteract spreading practices of deception would lead these reasonable persons to opt for accountability wherever individuals now exert influence over others in ways for which they cannot be held to task. At all times they have to look at the individual lie from the point of view that it might give rise to others' (Bok 1978).

An examination of some possible justifications of deliberate deception in a professional relationship

Nurses claiming justification for having deceived a patient or a relative appear to frequently offer reasons which, following the argument here, do not seem acceptable in principle. From a series of written questions to be answered anonymously by qualified nurses who were at the time participating in various postbasic courses, two examples presented in Tables 3 and 4 might illustrate this point.

Sixty per cent of the offered reasons for withholding the truth in response to a patient asking the name and/or purpose of a drug he was given would fall under the second type of excuse, to have acted under coercion (of the doctor's orders, of ward policy instructions). However, 27·5% appeared to evidence lack of confidence by the nurse to be able to handle the situation, if the patient had been told the truth (Table 3 Reasons 3, 6, 8, 9, 10). An excuse of ignorance or lack of skill on the part of the qualified professional worker would not seem to be a valid justification for lying or evading the truthful answer. Another 7·5% of the reasons appeared to have taken the interest of another professional into greater account than the interest of the patient (Table 3 Reasons 4, 5). Only 5% might, after discussion, have emerged as valid reasons for withholding information in two specific instances (Table 3 Reason 7). The percentage of reasons attributed to coercive influences of ward policy in withholding information from a relative who had asked what was wrong with the related patient matches the result in the first question almost exactly with 58·6%. Reason 3 in Table 4 (10·3%) and

TABLE 3 *Qualified nurses' justifications for instances of deliberate deception*

Question: If you have ever told a patient that you did not know the name or purpose of a drug that he/she was given (although you did know), why did you tell a lie or give an evasive answer?

Offered reason	*Student Group*				
	Health visiting students (16)	*Clinical teaching students* (9)	*Nursing administration students* (10)	*Clinical postbasic course students* (5)	*Total*
1 Doctor's orders	5	3	3	1	12
2 Ward policy	3	3	4	2	12
3 Expected patient to refuse drug	2	0	1	1	4
4 Patient had been told drug was changed but it was not	0	0	0	1	1
5 Patient believed another drug to be more effective	1	1	0	0	2
6 Patient would have known he had an illness he dreaded	1	0	1	0	2
7 Patient was addicted to certain drugs	0	1	1	0	2
8 Other patients might have started asking	0	1	0	0	1
9 Patient had told doctor that he would not take this drug as it made him feel bad	1	0	0	0	1
10 It would have taken too long to explain in detail	3	0	0	0	3

Reason 4 (6·8%) indicate an unacceptable lack of skill or knowledge while Reason 2 (24%) might after discussion of each individual case have revealed an acceptable justification for deliberate deception. With 95% of excuses in the first, and 76% in the second example being unlikely to be acceptable as justification for deception, the question what kind of reason might in principle be acceptable as a justification for not telling the truth must be raised.

The acute crisis

For those confronted with a crisis in which a patient may suffer serious physical or emotional injury, or even death, there is little time to reflect. It should be noted, however, that in the 69 instances of deceptions illustrated in Tables 3 and 4, not

TABLE 4 *Qualified nurses' justifications for instances of deliberate deception*

Question: If you have ever given an evasive answer to a relative of a patient who asked what was wrong with the patient, why did you do this?

	Student Group				
Offered reason	*Health visiting students* (8)	*Clinical teaching students* (7)	*Nursing administration students* (9)	*Clinical postbasic course students* (5)	*Total*
1 Ward policy not to give diagnosis	5	5	4	3	17
2 Patient had a malignant disease	2	2	3	0	7
3 Relative would not have understood	1	0	2	0	3
4 I did not know for certain	0	0	0	2	2

one was attributed to a crisis decision. None the less, they undoubtedly do occur and do not leave the nurse with any time to work out non-deceptive alternatives. The avoidance of certain harm befalling the person about to be deceived would outweigh the general principle of truthfulness that should operate in professional relationships. There would be no difficulty in defending the decision to tell the person poised to commit suicide a lie that can be expected to stop the person from committing an irrevocable act of self-destruction. While rushing to resuscitate a patient who collapsed in the presence of visitors, truthful and detailed answers to their anxious questions might clearly be not possible. 'Someone who advocated the policy of total honesty would be a dangerous individual in times where life and death crises arise, there are professional groups whose members can expect frequent crises in their work' (Bok 1978).

Prolonged threats to survival

In extreme and prolonged threats to survival as in epidemics affecting large numbers of people, human choice is intolerably restricted. One lie after another may barely prevent disaster and threats may reoccur which each time pose the issue of deception under the same conditions as may prevail in an acute crisis, i.e. no time for searching out non-deceptive alternatives and the necessity of preventing greater harm coming to people. In many discussions with nurses, few instances could be found that might create such prolonged threats to survival in the health care system in this country. Perhaps a just possible example may be a group of seriously disturbed mentally ill patients, who face an outbreak of an epidemic and can only be coerced into following a strict regime designed to halt the spread of infection by a deliberate series of lies or half-truths.

Defining a crisis

Many less urgent predicaments may still be perceived as a crisis or even as a series of crises by those who practise deception on their patients. They may want to be relieved of an unpleasant obligation and offer the excuse that there is no time to consider carefully any alternatives to the deceitful practices. Examples of almost standardized evasions of the truth abound in relation to dying patients. The excuses forwarded for an adherence to what are deliberate lies, contain a mixture of alleged coercion, lack of knowledge or certainty, and lack of time for the contemplating of a particular individual's needs and interests.

Prolonged threats to professional survival are also put forward by nurses in justification of going along with deceptive practices e.g. in a mental hospital. Here the conflict between self-interest to merely survive in a job and the violated interest of patients becomes very apparent. It would be naive to suggest that self-interest should always be deferred to the interest of the patient. A nurse might feel obliged to assist a patient detained in a hospital to contact a legitimate authority in order to have his situation reviewed. If the patient has been prevented from doing so by the deceptions practised upon him by other members of staff, the nurse may only be able to help him by telling a lie. For example, she may post a letter for the patient addressed to his Member of Parliament although the charge nurse has forbidden this (wrongfully).

'These situations differ with respect to the proportion of persons who actually participate in the deceptive practices. They differ with respect to the degree of voluntariness of participation, depending upon the consequences of noncompliance. In all these cases, the claims to justification vary; liars will tend to overestimate the forces pushing them to lie' (Bok 1978).

PROTECTING CLIENTS AND COLLEAGUES

Difficult choices may arise for nurses and doctors whose professional conduct endeavours to safeguard the confidences that they may have received from a patient. Nurse managers will have to decide whether there is any non-deceptive alternative to answer the inquiry about the psychiatric record of a member of staff. Often silence is the strongest indication that something is amiss which the doctor or the nurse manager have endeavoured to keep confidential on behalf of the patient, or the member of staff, to whom the right of confidentiality of privileged information belongs.

There are three claims which might justify a deliberate evasion or even a deception on the part of the person who holds the privileged information. He has a right to protect himself and his client from any harm which disclosure may bring; fairness requires a respect for privacy and added strength is given by the implied or explicit promise to keep confidential any privileged information. The first claim appeals to the principle of avoiding harm. The lie to protect a patient or a colleague may prevent injuries to their lives. The second claim involves the right to privacy. Into this category fall all the potentially illegitimate inquiries regarding political beliefs, sexual orientations or religious faiths. Honest answers

to such inquiries may well rob clients or colleagues of their employment or of the respect accorded to them by others. Refusing to give information that could blacklist a patient or colleague may be fully justified and lying in such instances may fall into the category of responses to a crisis. The third claim in defence of deception in order to maintain confidentiality rests on the expectations in professional relationships that hold the promise of secrecy, unless it has been made explicit by the professional that he will not be held to this promise in a specific situation. It is, however, in this area of potential conflict that the perspective within a profession can be limiting. 'The bond of confidentiality can dim the perception of the suffering imposed on outsiders' (Bok 1978). The appeal to the sanctity of promises adds no justification to an undertaking that in itself is wrong or that protects anyone who places others at risk. Professional loyalty is clearly outweighed by the duty to prevent grievious harm. 'It is time for health professionals to look closely at the threat which incompetence poses, and at the conflicts between loyalty and responsibility' (Bok 1978).

The patient's perspective

Withholding from or distorting information given to patients has been traditionally justified by nurses and doctors in a rather simplistic way. Claims that truthfulness is impossible, that patients do not want bad news, and that truthful information might harm them rest largely on the paternalistic assumptions of professional superiority. An attempt to deal with the first claim was made earlier. The second claim has been refuted by one study after another which show that the large majority of patients say that they want to be told the truth. A rather dubious response to this evidence is to make the counterclaim that although patients say that they want to be told the truth, they do not *really* want to know!

Even doctors and nurses who admit to the patient's right for honest information may still not provide it and may invoke the third claim that it might harm them.

> 'The factual basis for this argument has been challenged from two points of view. The damages associated with the disclosure of sad news or risks are rarer than physicians believe, and the *benefits* which result from being informed are more substantial, even measurably so' (Bok 1978).

Even the fear that patients will be driven to suicide by being told the truth, has been put forward as a justification for deception, and has in turn been found to be largely groundless (Oken 1961, Weisman 1972, Veatch 1976).

Nonetheless, concealment, evasion or deception may at times be necessary. If a health care professional decides to lie to a patient or to conceal the truth, the burden of proof must rest, as with all deception, on those who advocate it in any one instance. A decision to deceive must be seen as the exception and reasons must be offered and discussed with those who contribute to the care of the patient. 'Trust and integrity are precious resources. They can thrive only on a foundation of respect for veracity' (Bok 1978).

Acknowledgement

This paper is written in memory of a man who died for telling the truth and in gratitude to the nurses and nursing students who contributed their thoughts and experiences.

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APPENDIX II

Schröck, R.A.

The ongoing process of reappraisal

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An investigation into the principles of health visiting

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APPENDIX II

Miss R. Schröck, a Lecturer in the Department of Nursing Studies, University of Edinburgh, was invited to join the Working Group at their first working week-end session. She subsequently joined the two workshops at Nottingham and Loughborough.

The members of the Working Group are grateful to Miss Schrock for her interest and involvement in the task of re-appraising the principles and practice of health visiting.

Miss Schrock's leadership and clarity of thought were of great benefit to members of the workshops when she led the plenary sessions. Through her analysis of the work of the small groups, she enabled the participants to perceive relationships in the material which were not previously obvious.

The Ongoing Process of Reappraisal

An edited version of the paper by Miss Schrock

The beginning of the process is very important. It illustrates the start of all those activities which, although called by various names, have a common denominator in the endeavour to reappraise, eg., research, conceptual revision, theory construction, examination of principles or even ideological reassessment.

The first two steps in this process are:

1 Established practices and explanations are being questioned by the practitioner.

2 Questioning arises out of the realisation that the established practices no longer seem to:
   (a) fulfil the demands made on the practitioner by the client or consumer (or by the material)
   (b) provide the practitioner with a measure that he/she is operating satisfactorily or efficiently and that current explanations for these practices no longer help to:
      (i) order and predict events with any certainty
      (ii) provide an acceptable rationale for practice.

This state of affairs is often experienced as a scientific or professional crisis. Suddenly, it seems, the old concepts and modes of thinking which appeared to have provided a perfectly satisfactory basis for a particular scientific or professional activity, are not only inadequate but also strangely uncertain. The dilemma experienced by people in such situations is almost bizarre.

No one would doubt that there is a group of people called health visitors. They exist, they carry out observable activities which can be described and categorised and compared with the activities of other people. These are matters of fact, open to verification. But, at the same time, the strange question arises whether in fact there is such a thing as health visiting. What has happened?

To emphasise the point: no one would deny that there are people who call themselves health visitors. We can count them, classify them by age or sex, describe their work and their clinets and so on. But this does not answer the question whether there is such a cognitive, conceptual entity which we can call health visiting as distinct from similar but other entities. So what we are encountering here is a conceptual problem.

To find the answer we would waste time, if we tried to learn more about health visitors, or about their work as it can be seen to be done, or about the things which they learn in the course of their training and education. We must focus our attention on the criteria in virtue of which we say that all these factual phenomena can be conceptualised under the term 'health visiting'. We must find out the rules in terms of which expressions are correctly or incorrectly used and we must particularly attend to the reasons which these criteria and rules embody, i.e. why we should draw one distinction rather than another, why we should characterise actions in one way and not in some different way.

That the participants at the 1974 Wansfell Conference were not in need of more factual information about health visiting or about health visitors was poignantly indicated by the statement:

> It was not easy to clarify the principles of health visiting except that they appeared to be expressed in ethical terms and shared with other caring professions. The conference ended with tutors questioning whether there were principles more specific to health visiting.

At this point the third step and the fourth in the process of reappraisal had been reached:

3 Uncertainty is experienced by the practitioner not only about various concrete aspects of his/her activity, but about its whole purpose or meaning.

4 Formerly specific aspects or variables have lost their specifity and have become diffuse by escaping precise definition.

It is at this stage that one must realise that the only solution lies in abandon-

ing, at least for the time being, any attempt to add to, to refine or to rearrange the specifics, both the factual and conceptual content.

Whether this realisation and the resoluteness required to translate it into action is always allowed to become fully conscious, is a fascinating but also a crucial question. Particularly in all those human activities where time seems to be pressing in one way or another or where the demands on the practitioner are uninterrupted or even increasing, the above demand seems impossible. To abandon, even temporarily, the conceptual structures which so far have given a modicum of security during a process which by itself generates uncertainty, demands a great deal of courage. Or, to put it another way, to solve the increasing uncertainty, one must first create even more, and perhaps deliberately, total uncertainty! This is, as one may appreciate, a rather frightening prospect both for the individual and the group.

But this is the fifth step in the process of reappraisal:

5 By questioning the fundamental assumptions underlying the practice of the explanations, an even greater degree of uncertainty is created.

This, however, is what occurred during the early meetings of the Working Group which had been set up in 1975.

It may have been a fortunate coincidence and indeed, may not have been seen at the time to be a positive factor, that in asking me to contribute to the deliberations, a further source of creating more uncertainty was introduced into the process. The uninhibited questioning of some fundamental assumptions underlying the practice of health visiting was necessary, since these were meaningless unless the criteria for using them were spelt out in minute detail. It soon became apparent that what had once been a fairly effective framework for all these activities which we call health visiting had become insufficiently wide or flexible to accommodate all the developments which had taken place over the last twenty years. The next steps in the process are:

6 Reconstruction which starts with the identification and analysis of key concepts relevant to the practice under scrutiny.

7 Before these key concepts can be reorganised into a new, more effective conceptual framework, the field of conceptual enquiry must be extended in two ways:

(a) the use and meaning of these very same concepts must be examined in any other area where they appear to be of significance and their meaning and relationship in these other areas must be analysed.

(b) related 'questions' or 'problems' must be identified and reduced to the concept which is being 'questioned' or which proves 'problematical' so that these concepts can be incorporated into the continuing process of reappraisal.

This latter activity occupied much of the participants' time and effort during the days of the Nottingham Workshop. It alternated and was inter-related with what one must call the stage of 'experimenting with parts of a usable model'.

8 Conceptual and paradigmatic experimentation involves trying out and usually partly accepting and partly discarding various elements. This stage of experimentation must attempt to test any suggested solutions (or parts of a solution) for
   (a) inherent consistency (informal logic)
   (b) its explanatory value and power of the practice under scrutiny.

There is a danger that this phase can be prolonged and extended to such a degree that it becomes more and more difficult to correlate what is happening. Therefore the next step must be attempted, even tentatively, to keep control over the process:

9 Definitions and paradigms must be formulated and must be used to incorporate any new elements and any new part solutions.

There is a possibility that a point is reached where the attempted definition and the provisional paradigm or the set of principles prove unworkable. This, however, does not mean that a start from the very beginning has to be made. If a careful record of the criteria and rules expressed in these conceptual structures has been kept, it can fairly easily be seen in what way the solution so far attempted is still valid and in what specific way it has to be modified.

The next stages can be summarised in the last three steps:

10 Conclusive conceptual and paradigmatic statements must be made.

11 The specific question/problem which started off the process of reappraisal must be answered/solved.

12 The 'new' concept/model/set of principles/theory must be shared with all practitioners and must be tested in its application to the practical endeavour under scrutiny.

However, the twelfth step should not literally come 'at the end' but the whole development of the process of reappraisal should be shared to the greatest possible extent with the practitioner.

APPENDIX III

Schröck, R.A.

Philosophical issues

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Philosophical issues

The search for knowledge

Observers of nursing in the United Kingdom during the past seventy years should have recognised a major change in the development of the profession since its 'coming of age' in 1919 when responsibility for the training, education and registration of nurses was taken over by the General Nursing Councils. The steady flow of reports on nursing from the 1930s onwards indicated clearly that all was not well in the provision of the quantity and quality of nursing care (Baly, 1973). The suggested solutions to the problems which apparently beset the profession in the first half of this century concentrated largely on the need for recruiting and retaining more nurses. This implied that more nurses would provide more and better nursing care.

From the 1950s onwards the demand for more nurses was frequently accompanied, if not entirely substituted by an ever more strongly expressed desire for a new knowledge in nursing. To have and to hold more nurses as such appeared no longer to be the only solution. If more nurses were needed, they also needed to be different.

In *A Reform of Nursing Education* (1964) the hope that the 'study of nursing would become a suitable subject for study at university level' was expressed for the first time in a published report. The *Report of the Committee on Nursing* (1972) reaffirmed on a broader basis this new look at nursing and demanded that efforts should be directed towards making nursing a more research-based profession. It was no longer felt to be sufficient for the education of the professional nurse of the future to 'remain at the level of a training in procedures'. Such skills as nurses may acquire have 'to be supported by a rationale, a scientific basis for action'. A theoretical basis for nursing action, well founded in scientific principles, many writers agree, is essential to the provision of effective nursing care. Although nurses are as yet in the early stages of theory construction and are still engaged predominantly in the endeavour to describe methodically and systematically what actually happens in nursing, the search for a new knowledge in nursing and the efforts to 'see nursing in a new light' have produced a 'useful literature

exploring the basic conceptual framework of nursing. . .' (McFarlane, 1976).

Conceptual revision

One kind of philosophical activity is a process known as 'conceptual analysis' (Wilson, 1963) by which philosophers attempt to clarify and define the concepts, notions and ideas which are the foundations for a particular scientific or professional inquiry but which the scientist or professional uses pragmatically and empirically. Always (Kuhn, 1962), or at least very often (Ryan, 1970), it is in times of crisis, scientific or professional, that suddenly the old concepts which had seemed to provide a perfectly satisfactory basis for a particular scientific or professional activity, no longer suffice in the ordering and predicting of events. It is at this point that an attempt is made to restructure or to recreate the major concepts in a particular field of human endeavour. The kind of crisis that shakes the epistemological foundations of a discipline or profession appears to be affecting nursing at present. Traditional nursing 'knowledge' is no longer accepted generally or totally as either adequate, valid or relevant to those activities which are called nursing (Scott Wright, 1973).

It requires a lengthy and complex historical and philosophical argument to examine in depth the causal relationships between the increasing uncertainty of what might constitute 'real nursing knowledge' and the apparent conceptual confusion of what kind of caring activities should properly be called 'nursing'. The traditional concept of 'care' along with the knowledge and skills generally acquired by nurses no longer seem to fit either the experiences or the ambitions of nurses who wish, and are often asked, to demonstrate that they are engaged in an effective caring activity that is sufficiently distinct from that of other health care workers to be conceptualised as a separate entity, i.e. as 'nursing'.

The growing literature concerned with the 'process of nursing' (Kratz, 1979) illustrates the fundamental re-thinking that is attempted in nursing today. Although this kind of conceptual revision is a relatively recent phenomenon in British nursing, making its first appearance in the mid 1970s, it has aroused already distinct apprehensions in those who engage in these revisionist activities and in those who fear to become the unwilling recipients of a great deal of useless 'theorising'. While the former group is anxious to see its new models of caring applied in the actual activities of nurses, and is therefore justifiably apprehensive of any expression of rejection by the nurse practitioner, the latter frequently anticipates little benefit and an additional burden to an already heavy workload. That this gulf

should be generated in the first place and by its existence propound the problems which were to be solved at least partially by a conceptual revision of the whole enterprise called 'nursing', illustrates the difficulties in producing a shared understanding of the process of conceptual reappraisal.

Questions and answers

Philosophical analysis, of which the process of conceptual reappraisal in only one example, is an essential preliminary to any sort of answer to a question. One must first analyse the question in order to discover what it means and how one would set about answering it. One cannot sensibly answer any question without first discovering what sort of answer would be relevant and indeed, useful to the purposes of the questioner (Popkin et al, 1969). If the questions that are asked by nurse practitioners and nurse theorists are not analysed, and no shared agreement is reached about their meaning and about what might count as a relevant answer, a variety of largely unconstructive situations may arise.

Answers to unasked questions

The nurse practitioner is not asking any questions and is therefore not expecting any answers. If one assumes that the question to which nurse theorists have supplied the answer in the nursing process literature is about the best means towards effective nursing care, one can see clearly where the gulf between nurse practitioner and nurse theorist may have originated. The nurse practitioner is not asking questions about effective nursing care and therefore the answer of the nurse theorist (to an unasked question) is not only seen as meaningless but may be perceived as threatening in the sense that the nurse practitioner is made to feel guilty for not having asked the question to which the answer is now offered.

Answers to different questions than those asked

The nurse practitioner expects answers to different questions than those which the nurse theorist has chosen to examine and to answer. The nurse practitioner may be asking questions about how to cope with new managerial responsibilities and cannot share the priorities nurse theorists perceive. Again the offered answers embodied in the conceptualisation of the process of nursing appear irrelevant and burdensome, since they seem to be answering a different kind of question.

Unacceptable answers to the question asked

The nurse practitioner and the nurse theorist are asking the same kind of question but differ in their expectations of what is to count as a relevant answer. Both may be asking questions about means towards effective nursing care but the nurse practitioner is expecting an answer in terms of manpower development and does not accept the offered answer in nursing process terms as a valid and relevant solution.

Acceptable answers arrived at by chance

By chance, the nurse theorist may select and examine a question that is being asked by nurse practitioners, and may provide an answer that is found to be valid and relevant within the practitioner's current conceptual frame. Here one may find the comparatively rare occasion when almost against all expectations an idea takes root and becomes incorporated into the ideational fabric of the profession. However, one not uncommon danger may lurk in this situation. The answer that is so unexpectedly and speedily taken up into an essentially unexamined conceptual framework may be somewhat transformed into practice activities which were not desired by the nurse theorist.

A perfectly acceptable philosophical approach to avoiding the unconstructive cross purposes and conflicting expectations surrounding questions and answers is open to the nurse theorist who wishes to preserve an individual starting point in the search for knowledge. To arrive at specific conclusions and then to determine what kind of practice questions these may answer, by whatever method of inquiry that offers itself for the 'attempt to increase available knowledge by the discovery of new facts through systematic scientific enquiry' (Clark & Hockey, 1979), is a legitimate scientific endeavour. It entails the analysis of questions that nurse practitioners may be asking with a view to identifying those that may be answered by the theoretical conclusion already arrived at. Much research that sets out to duplicate previous studies utilises this theorem. This does not contradict the earlier assertion that question analysis is an essential preliminary to any sort of answer. Here it becomes the identical preliminary to fitting an already formulated answer to a possible question. What remains a frequently unsolved philosophical issue in nursing is the lack of, or deficiency in, the analysis of nursing questions either before or after a theoretical answer has been formulated. However, more usually the search for a new knowledge via the process of conceptual reappraisal finds an effective expression in changed practices when it becomes a shared endeavour between the nurse theorist and the nurse practitioner.

The process of a shared conceptual reappraisal

Following Kuhn's argument (1962) one would expect successful conceptual revision to be generated by the practitioner who will remain actively involved in its various stages. The following outline of the process of reappraisal (Schröck, 1977) illustrates the essential interaction between the conceptual revision and its application to the practice whose knowledge base it is endeavouring to clarify and to define.

The beginning of the process is very important. It illustrates the start of all those activities which, although called by various names, have a common denominator in their attempt to reappraise, e.g. research, conceptual revision, theory construction, examination of principles, or even ideological reassessment.

The first two steps in this process are:

1. Established practices and explanations are being questioned by the practitioner.
2. This questioning arises from the realisation that the established practices no longer seem to:
   a. fulfil the demands made on the practitioner by the client or consumer, or by the material
   b. provide the practitioner with the confidence of operating satisfactorily or efficiently and with explanations that help to:
      (i) order and predict events with any certainty
      (ii) provide an acceptable rationale for practice.

This phase is experienced as a scientific or professional crisis when the current knowledge base appears not only inadequate but also dubious in principle. Ryan (1970) describes this experience as 'a crisis of scientific confidence' in which 'currently accepted techniques yield results which seem not just unsatisfactory, but unsatisfactory in principle. . .'. The practitioner, who is dissatisfied with the knowledge and explanations that are available, may well continue to expect solutions to this uncertainty to be provided by more knowledge of the kind that so far has been accepted as relevant to the practice. Nurses in this situation may similarly demand more detailed and more complex procedural instructions or an extension of the familiar medical knowledge based curriculum.

As an accession to these demands fails to restore confidence in the practice of nursing, the third and fourth step in the process of reappraisal have been reached:

3. Uncertainty is experienced by the practitioner not only about various concrete aspects of the professional activity, but also about its whole purpose and meaning.

4. Formerly specific aspects or variables have lost their specificity and have become diffuse by escaping precise definition.

It is at this stage that the only solution lies in abandoning, at least for the time being, any attempt to add to, to refine or to rearrange the specifics of both the factual and the conceptual content of the current knowledge base. Whether the resoluteness that is required to translate this realisation into action is always allowed to enter into full consciousness is a fascinating and crucial question. Particularly in all those human activities where time seems to be pressing or where the demands of clients on the practitioner are uninterrupted or even increasing, a deliberate and total abandoning of current conceptualisations may seem impossible. To give up, even temporarily, the conceptual structures which so far have provided a modicum of security during a process which by itself generates even greater uncertainty, demands a great deal of courage. But unless the practitioner is content to forego any control over the development of the discipline or profession that has reached a critical stage of uncertainty and dissolution, the fifth step in the process of reappraisal is inevitable:

5. By questioning the fundamental assumptions underlying the practice, its rationale, its knowledge and its values, an even greater degree of uncertainty must be created.

Since a crisis of confidence is not caused by trivial inconsistencies in the practice of a discipline or of a profession but by its inability to accommodate and utilise developments which threaten to change its central character, a superficial rearrangement of concrete practices will contribute nothing towards its solution. British nursing at the end of the 20th century must assimilate ideas such as need, individuality, participation, self-determination, right, accountability, power, and many more which have been instrumental in the recent general development of that society to which nursing belongs and in which it has to function. Without a questioning of the assumptions that created a model of nursing care which now appears to be increasingly inadequate, a conceptual reconstruction in the next three steps of the process of reappraisal is not possible:

6. Reconstruction starts with the identification and analysis of key concepts that are relevant to the practice under scrutiny.

7. Attempts at clarification and definition must take into account the significance of these concepts in any other area of professional practice where they appear to be as significant as in nursing, and

related 'questions' or 'problems' must be reduced to the concept which is being 'questioned' so that they can be incorporated into the continuing process of conceptual reconstruction.

8. Conceptual and paradigmatic experimentation involves trying out and usually partly accepting and partly discarding various elements of a usable model which must be tested for its inherent consistency and for its explanatory value and power in relation to the practice under examination.

There is a danger that this phase of conceptual clarification and paradigmatic experimentation can be prolonged and extended to such a degree that it becomes almost impossible to monitor and to correlate what is happening. In the absence of any correlation during a proliferation of conceptual models of nursing, the nurse theorist can become almost compulsive in the search for an irrefutable nursing paradigm, while the nurse practitioner fails increasingly to see the purpose of what may not be described too inaccurately as intellectual acrobatics which are fun to perform but often frightening to watch (Rickelmann, 1971). This is not to advocate the imposition of one conceptual model in arbitrary preference over one or many others.

Scientists frequently make use of a 'model' to describe more clearly the relationships between concepts. A model is an analogy that is used to help visualise and understand something that cannot easily be observed directly or about which little is known. It is often argued with some justification that a good model is one which holds together long enough to allow the development of a better one. In many instances, however, it seems that the development of ever more complex theoretical constructs in nursing proceeds without the necessary testing of their explanatory usefulness for the nurse practitioner. Jacox (1974) sums up the discussion of a highly abstract kind of mathematical model that is used to express the interrelationships among persons, actions and events in numerical form, by saying: 'As long as no one is fooled into prematurely believing that the model accurately and simply describes and explains (nursing), little harm may be done and new insights may be produced.'

Nevertheless, to keep control over the process of reappraisal which after all should serve a practical end by helping to re-establish a well-founded confidence in the practices and explanations of the discipline or of the profession, one must attempt the next step:

9. Definitions and paradigms must be formulated and having incorporated any new elements and any new part solutions, they must

be tested against the specific questions and problems which started off the whole process of reappraisal.

If one now recalls that these specific questions and problems had been raised by the practitioner in the first place, it becomes abundantly clear that the last step in this description of the process of reappraisal should not literally come 'at the end' but should accompany each step as it occurs:

10. The 'new' concept, model, set of principles or theory that has been developed must be shared with all practitioners and must be tested by them in its application to their practices.

It is part of Kuhn's (1962) and Ryan's (1970) arguments that the practitioner of a discipline is unlikely to inquire into its logical and epistemological foundations at times when current problems are soluble in currently acceptable ways. But practising scientists do engage 'in philosophical scrutiny of their own practices once they are beset by doubts of a particularly striking sort' (Ryan 1970). One need not be committed to the view that the nurse will become a better practitioner by being diverted to a consideration of philosophical issues in nursing in those times which might correspond to Kuhn's (1962) periods of 'normal science' when established concepts can be used pragmatically and empirically to good effect. But when there is a crisis of confidence, 'the line between science and its philosophy becomes much harder to delineate exactly' (Ryan, 1970). It then seems not only desirable but necessary that the practitioner should understand and participate in the philosophical method of inquiry which 'uses the tools of logic and reason in an attempt to extend knowledge' (Clark & Hockey, 1979).

While a conceptual revision in times of crises may lead to successful theoretical innovations and to a new kind of knowledge, there is no reason to believe that philosophical inquiry in nursing only flourishes in such times.

Philosophy and ideology

At all times people have a tendency to cling to a variety of myths about man and the world, about the past, present and future. Nursing like almost any other human activity is surrounded by myths which rest on 'numerous clichés, platitudes and strange contradictions which point. . . directly or indirectly to a set of unsubstantiated beliefs held by nurses. . . who (have) been imbued with the lore of nursing' (Reinkemeyer, 1969).

Many such beliefs centre on the apparent impossibility to define nursing. At the same time, they are accompanied by a ceaseless quest

for such a definition. Few attempts have been made by nurses to examine closely 1) the functions that definitions generally serve, 2) what kind of definitions one might construe and 3) what specific purpose any one definition of an object, a person, a group of people, an activity or a situation might fulfil. An understanding of the nature of definitions would lead to constructive attempts at defining nursing and would also expose the belief 'that the glorious thing about nursing is that it cannot be defined' (Storlie, 1970) as false.

Other clichés and platitudes seem to have been equally resistant to objective examination: British nursing is the best in the world; nursing standards have deteriorated (since the introduction of a revised senior nursing management structure, since the reorganisation of the health service, since the joining of the European Economic Community, since the teaching of nursing in universities and colleges, since the individual's own training days); nurses may not make mistakes since almost everything they do is a matter of life or death; nursing is an art based on common sense; nurses know intuitively when what they do is 'good', but it eludes description; nurses are born, not made; nurses cannot be educated and dedicated at the same time; good nursing students are poor nurse practitioners (and vice versa); nursing can only be learned at the bedside.

The issue here is not whether any or all of these beliefs are true or false, but that they are accepted uncritically by and large by a professional group of people and are incorporated into a persuasive ideological structure which has significant consequences for the tasks and relationships of the nurse (Williams, 1974). In the course of time, many unexamined and unproven assumptions and beliefs which are held with a certain degree of fervour and conviction by a definable body of people are incorporated into 'an integrated and consistent personal attitude toward life and reality' which 'underlies' a nurse's central and shared purposes (Wiedenbach, 1969).

It is certain that such an ideological structure serves 'to increase. . . loyalty to the community and to each other' (Plato, 1955) and that it is fundamentally necessary in 'the selection of modes, means and ends of action' (Godfrey, 1971). However, it is also important to note that it does not do justice to the contribution which philosophical methods of investigation can make to the study of nursing, if one confuses an 'ideology' with a 'philosophy' of nursing.

Whether the prevailing ideology of nursing 'constitutes worthy means and ends for a given practical endeavour' (Walker, 1971) is not for the philosopher to decide in spite of the spreading transatlantic custom to talk in the above sense about a 'philosophy of nursing'. Philosophical issues in nursing are not exemplified by a collection of

assumptions and beliefs, even though a philosopher might be intrigued by the lack of internal logic demonstrated in ideological systems in nursing as elsewhere.

The philosophical perspective

The philosopher shares with the historian and the scientist the common goal of increasing man's knowledge about himself and about the world in which he lives (Silva, 1977). The discovery of new facts through systematic scientific enquiry is the scientist's task. However, before and after the scientist employs an experimental research design with its rightful emphasis on causality (asking e.g. whether certain explanations given by nurses to a preoperative patient affect his pain experience postoperatively), the use of the philosophical perspective facilitates the identification of the research problem, the construction of an appropriate theoretical framework, the establishment of conceptual relationships, the formulation of meaningful hypotheses, the selection of criteria of proof, the processes of valid generalisations, and the synthesis of any newly discovered or substantiated 'facts' with already existing (nursing) knowledge.

Regardless of any philosophical analysis of the nature of 'facts', scientists do not usually set out to 'discover' unrelated facts. They look for specific facts, order, relate, interpret and generalise from them. All these are conceptual activities which acknowledge: 'Facts (to) be sets of objects in the world related in certain ways' and which view facts as 'things in the world corresponding to parts of thought and language' (Lacey, 1976). In day to day scientific work, these operations are normally performed by the scientist who draws on the discipline's philosophical foundations. These foundations are examined, clarified and consolidated by the philosopher of science, social sciences, history, education, mathematics, or nursing, who does not ask questions in these sciences but who poses questions about them (Ryan, 1970).

First- and second-order inquiries

It is helpful in distinguishing between scientific and philosophical questions (and answers) to consider the different kind of questions that one may ask about any phenomenon or experience. One may ask factual questions to which the answer can be found by observing, counting, measuring and testing. Anyone who uses the same tools of measurement should be able to repeat the investigation and to arrive at the same results. If one stated the fact that x-number of patients in a given place were recovering from a surgical operation, the observable evidence of recent operation wounds would make it possible for any

trained observer to verify this fact. In other words, the answers purport to be accurate reports of what the facts are like and must be defensible in terms of the known methods for getting at these facts. These kinds of first-order or factual questions are the concern of the scientist.

What makes second-order or philosophical questions different is that they cannot be decided by an appeal to any of the known methods of observing, counting, measuring and testing, i.e. they cannot be answered by scientific investigation. If one were to ask how many nurses there were caring for the mentally disturbed patients in a given locality, one would quickly discover that the scientist could not even begin to observe, count or measure until some agreement had been reached on who were to be counted as a 'nurse' and by what criteria one would identify the 'mentally disturbed patient'. What has here to be questioned and answered first are not any potentially observable facts, but how certain phenomena are to be characterised so that they become observable, countable and ultimately comparable.

It might be argued that such verbal definitions of conceptual entities are purely conventions and apply only because of an agreement that they should apply. Those who consider a close conceptual examination to be a superfluous exercise might call it 'simply semantics'. But it can cause a fundamental weakness in nursing research (as in other social science research that is concerned with the complexities of people in social relationships), if there is no reasonable concensus on what verbal agreements exist and on the necessity to maintain such an agreement from one occasion to the next, to provide the consistency that is essential to all scientific investigations (Ryan, 1970). Without such concensus, scientific investigation may become trivial and almost certainly so narrow that it has little or no meaning for nursing practice. The pursuit of experimentation for its own sake in a professional context needs questioning. Cook & La Fleur (1975) maintain that scientific investigation that is not supported by a thorough and competent philosophical analysis and synthesis is becoming a dead end, as meaningful nursing action cannot be understood by the method of experimental research alone.

There is general agreement among philosophers that, at the very least, philosophical inquiry aids the understanding of that knowledge which has been obtained by appropriate methods related to the matter in hand. Apart from its contribution by conceptual analysis to the consistency of scientific inquiry, the methods of philosophy provide the 'informal logic' and the means for a consistent argument in any discipline or enterprise to which they are applied.

Although this is not the only contribution that philosophy has to make to the understanding of nursing, it must still be argued that removing contradictions and confusion from the realms of nursing discourse and eliminating linguistic uncertainties are by themselves important services.

The demythologisation of nursing ideology

It has been submitted that a nursing ideology serves a unifying function in helping the practitioners to select modes, means and ends of nursing actions, and that it allows the emergence of central and shared purposes. Any ideology, however, that is largely based on unsubstantiated myths runs the risk to be found wanting in the face of reality as soon as it becomes feasible to account for the facts which constitute that reality in a systematic and coherent fashion. If the beliefs and values which make up the ideological framework of nursing no longer guide the practitioner effectively and safely but cause uncertainty and frustration when confronted with factual evidence that does not support them, an ideological revision becomes an urgent task. From the beliefs and values which were based on myths (i.e. unsubstantiated assumptions which served the same purpose as man's belief in a flat earth at the centre of the universe when no factual evidence was available to help order man's thinking about his world in any other way), nurses must progress to beliefs and values based on the observable facts of reality.

Again it is a question of creating an internal logic by identifying those aspects of nursing ideology which are clearly contradictory and therefore by definition cannot be true at the same time. One such contradiction is e.g. expressed in the firmly held but unsubstantiated belief that more nurses means better nursing care given to patients, alongside the fact that there are more nurses now than ever before and the contradictory belief that nursing care standards are falling everywhere. Only one of these beliefs can be true. Only one of them can be potentially supported by facts if there is any causal relationship between the number of nurses and the standard of nursing care at all. One of these beliefs must be eradicated, if nursing ideology is to acquire a sounder logical, conceptual and factual basis and serve its proper function. The nature of philosophy as an uncommitted inquiry and the prevailing view among philosophers that it is not their business to advocate any ideology (or 'Weltanschauung') should single out the philosophical perspective as the valid approach to any attempt at an ideological revision.

Dickhoff & James (1970) suggest that nurses might cultivate profitably certain philosophical practices, e.g. to entertain systematic

ambiguities and even promote them actively in order to prevent a quick substitution of one (exposed) unexamined belief for another (not yet exposed) myth; to suggest and work with new terms and new structures when the old and familiar are deemed inadequate; to render overt and explicit, and to exploit constructively errors, difficulties and embarrassments; to seek simplicity of action through principles rather than through further selection of more closely and more rigidly defined detail; to use examples of personal, subjective experiences as mere heuristics (i.e. as a means to find methods of discovery) and not as 'proofs' which will add to rather than subtract from the mythical qualities of nursing ideology; and to risk purposeful disorientation as a step toward a richer reorientation (i.e. to have the courage to dismantle the crumbling ideological edifice of prevailing nursing myths in order to facilitate the growth and development of reality based beliefs and attitudes).

Moral issues

Everyone who is troubled by certain situations in life might be reflecting on the rightness and wrongness of possible and potential behaviours. Moral questions engage almost every human being who is trying to solve a particular personal value problem, and who is attempting to do this by deciding consciously and conscientiously on a specific course of action in the given circumstances (Popkin et al, 1969). Morality concerns that behaviour which involves judgments, actions and attitudes based on rationally conceived and effectively established norms. The behaviour can be judged right or wrong. It can also be judged good or bad depending on the values of society (Jonsen & Hellegers, 1974). It has been suggested that it is not the task of the nurse philosopher to determine which values nursing as a profession should adopt and pursue. The formulation and adoption of a professional code of ethics which embodies values that are held to be fundamentally important, is an ideological undertaking and not a philosophical one. Although 'descriptive ethics' are sometimes seen to be the philosopher's concern (Lacey, 1976), the examination of what moral views are held by nurses or by other groups of people or societies, and whether any of these are held universally, is strictly speaking a scientific rather than a philosophical enterprise. There is little doubt that values are 'facts' that can be ascertained by methodical and systematic inquiry using such tools of scientific investigation as observation and appropriate measurements of behaviour.

Most concerns in nursing that are related to moral questions appear to centre on two approaches: to establish — often preceptually — what values nurses should hold, and to find solutions to moral

dilemmas that nurses perceive to be important. Whereas the first of these approaches is not only a decidedly non-philosophical concern and could be held to be actually an immoral undertaking, the second endeavour may well be assisted by the contribution that a moral philosopher could make.

Ethics or moral philosophy is that area of philosophical theory which is concerned with understanding the nature of moral judgements. It is not concerned with providing moral guidance but with an objective analysis of universal principles and concepts (Campbell, 1975). Such an analysis might be applied to the concept of honesty or truth-telling, consider the nature of excuses or justifications and the processes by which people arrive at them, and establish criteria of lucidity, coherence and comprehension in relation to moral questions in nursing where solutions are required in matters of honesty.

It has been argued elsewhere that nurses generally do not seem to be greatly concerned with those moral concepts that have engaged the interest of many moral philosophers, e.g. truth, honesty, promise, loyalty, conscience, right, duty, obedience, power, reponsibility, accountability, and justice (Schrock, 1980). More precisely perhaps, nurses do not appear to exemplify, examine or discuss these concepts in relation to everyday nursing situations and thereby discover the practical implications of a formulated moral principle for their daily professional behaviour. There may be a connection between one of the prevailing myths (that all nursing actions are a matter of life and death) and the tendency of nurses to discuss such moral issues as euthanasia, abortion, resuscitation, organ transplantation, human experimentation and psycho-surgery (Campbell, 1975) in preference to more mundane but more common moral problems in health care. Telling patients the truth, respecting physical and emotional privacy, safeguarding adult rights, examining the limits of obedience in hierarchical structures, using but not abusing professional power, and preventing incompetent practices could all be examined very profitably from a philosophical perspective which cannot produce the instant solution to people's moral uncertainties, but which will provide the intellectual and emotional discipline that such an activity demands from the individual who is faced with difficult moral choices:

> The analytical attitude which it teaches prevents reliance on unquestioned assumptions, or on uncritical reactions to particular situations, as escape routes from thinking through the complexities of adequate medical care. (Campbell, 1975.)

In this area of concern as well as in those discussed earlier, the narrow and uncritical colloquial use of the term 'philosophy' by nurse

writers and speakers has seriously limited the potentially valid contributions which a 'philosophy of nursing' might make to nursing theory and practice.

Conclusion

Philosophy is aptly described as the endeavour to evaluate the information and beliefs of man about the universe and the world of human affairs and to see if they are rationally defensible (Popkin et al, 1969). Therefore its scope is practically limitless. One of its important concerns is the study of formal logic. The place of formal logic in theory construction in nursing would require a complex exposition. Nothing has been said here about the important fundamental issues of social and political philosophy, nor has their scope and applicability to nursing theory been examined (Campbell, 1978).

> All moral codes, all religions, all ideologies make some . . . claim about the world . . . All social theories are thus vulnerable to the ravages of the facts which may push them beyond the stage of merely having puzzles to solve to that presenting anomalies, and at this point, the revolutions which occur are not scientific ones, but political and social revolutions. (Ryan, 1970.)

It may appear to many that nurse theorists and nurse philosophers are engaged in a possibly stimulating pastime by attempting to solve intellectual puzzles. A rational defence of nursing knowledge and beliefs, however, is an urgent necessity in the face of its fundamental and often jealously guarded irrationality that sooner rather than later might lead it beyond the current crisis of confidence into social and political upheavals in which it would be unable to survive as a recognisable entity.

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